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A MILITARY HOSPICE MODEL

A Graduate Research Project
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of the Requirements for the Degree of
Master of Health Administration

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A hospice is a program concentrating on the care of the terminally ill and their families. It can be exclusively inpatient, exclusively outpatient, or some combination of both inpatient and outpatient. It involves an interdisciplinary approach by professional, staff, and volunteers interested in alleviating pain and assisting the patient and family cope with impending death. This study examines the feasibility of establishing a hospice at Fitzsimons Army Medical Center. It recommends that a pilot program for hospice care be created - citing a demonstrated need, the interest of the medical staff, the availability of assets, and the substantial asset savings that could be realized as important factors bearing on the decision. Keywords:

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Any large project is normally the result of the combined efforts of many people. In the case of the development of a hospice model for Fitzsimons a great deal of guidance and support have come from many Fitzsimons' staff members. Primary among these were CH (LTC) Fletcher D. Wideman and MAJ Royce Elaine Clark, ANC. Others who contributed valuable assistance outside of the FAMC family include James H. Sculley, M.D., Chief, Psychiatric Liaison Division, Veterans Administration Medical Center, Denver, Colorado, and M. Elaine Graves, R.N., Director, Hospice of Metro Denver, Inc. Special thanks is due to CPT(P) David Hinkle, Administrative Resident, General Leonard Wood Community Hospital, Fort Leonard Wood, Missouri, for his assistance in obtaining concept papers and other materials from the first hospice experiment established at an Army hospital.

I. INTRODUCTION

General Information

Part of the human condition is the process of dying, culminating in death. Much of the world's literature, such as the Koran and Bible, and many of the world's authors, such as Milton and Shakespeare, make the point that from the moment of birth man starts the journey toward death.[1] Serious inquiry into this process of death, however, has been avoided by most with a few notable exceptions.[2] The most famous of these studies has been the recent On Death and Dying by Elizabeth Kubler-Ross. Her work has sparked a renewed willingness to be involved in the process of dying by assisting with the associated problems affecting both the individual and the individual's support group.[3] This willingness to confront the various aspects of death has lead to the development of such new service areas as grief counselling for family members, aid in the preparation of living wills, and the development of the hospice concept.[4] Within the civilian community the usefulness of such programs and services is well established. By December 1982 there were more than 700 hospice programs operating in the United States.[5] The military community has not yet embraced these as either useful or necessary as evidenced by the lack of such services.

It is important to remember that what drives the military system is the requirements of the active duty population and

their needs for programs and services that will assist in the maintenance of a strong and able force. Because of this, the needs and the requirements of other beneficiaries of military programs and services, such as retired military individuals and their dependents, are often overlooked. The development of a hospice program by the medical care delivery system of the military may be one such area.

The average age of the population of the United States has been gradually increasing. With this has been a corresponding increase in the aged population (those 65 or over).[6] The diseases that now account for the highest percentages of deaths are not the acute, short duration disease processes but the long duration terminal processes. Primary among these are the various cancers and related disorders that proceed through a relatively predictable course. Just as an increasing percentage of members of the civilian community are afflicted by these processes, so are the many individuals entitled to care at military facilities.[7] Many of these individuals are treated for long periods as inpatients in military facilities. While on the surface this may seem inefficient, some examinations of cost-to-benefit have determined that this may be perhaps a more effective utilization of resources than an alternate type plan such as hospice if new staff members were required.[8, 9] Cursory examination of the magnitude of the need and of the available resources and considerations such as a teaching mission, geographical limitations, regulatory constraints, lack of interest and a host of other

factors may have caused the situation that we now see in the military, little or no movement toward implementation of the hospice concept.

Conditions Which Prompted the Study

The lack of hospice concept application to the military community and lack of movement toward serious consideration of the benefits to possible program participants in light of the increase in civilian community involvement is worth examination. (It should be noted that the one documentable example of a military medical treatment facility attempting to establish a hospice did not receive the sanction of higher headquarters. In this case the military treatment facility was the hospital at Fort Leonard Wood, Missouri, and the higher headquarters was Health Services Command. The lack of sanctioning was evidenced by Health Services Command's disapproval of a Request for Approval for Formal Establishment of the Hospice Care Program at General Leonard Wood Army Community Hospital. This disapproval was issued 15 December 1981, for the Commander, and signed by the Chief of Staff, HSC.) In the recent past there has been a steady growth in the number of individuals who are eligible for militarily provided medical care. Increasingly, these individuals are congregating in communities around military medical centers. Many of these individuals could possibly benefit directly from hospice care. Other family members, such as married sons or daughters who would otherwise be ineligible for militarily provided care, would benefit indirectly from some of the

ancillary professionals serving on a hospice team. In the past when attempts to apply a cost to benefit equation to hospice care have been made, many intangible benefits have been left out. Additionally, it appears that many believe only the aged become terminally ill and could possibly benefit from a hospice or similar supportive care organization. This is not the case. Many children and young adults are stricken with terminal disorders. They, too, can benefit from hospice type care.[10]

Fitzsimons Army Medical Center has no well defined geographic area of support or large active duty troop concentration on which to draw its patients. It does, however, serve a considerable retired population and a large active duty Air Force population in the Denver-Aurora, Colorado, area. Over the last five years there has been an average of 245.4 hospital deaths per year. Calendar year 1982 was somewhat lower than average with 229 hospital deaths. A survey of the most recent 18 months, 1 October 1981 through 31 March 1983, disclosed that there were 321 hospital deaths. Infant deaths (those individuals less than seven months of age) accounted for 26 of the records viewed leaving a net 295 deaths studied. Of this number 141 of these individuals could have been classified into a terminal patient category. The basis of this determination was provided by physicians from the Denver Veterans Administration Medical Center who used the diagnosis as to cause of death on the death certificate as a primary indicator if the person would not have been responsive to curative therapy for at least two months prior to

death.[11] By using this classification 47.8 percent of the hospital deaths at Fitzsimons over the past 18 months could have been classed as terminal. The average age of all deaths at Fitzsimons of the 295 records that were examined was 58.3 years. The average age of those classified as terminal was 58.1 years.

Records for the period 1 October 1981 through 31 December 1982 were examined to determine several variables. This particular group of records was selected because records with a later date were not all complete or later hospital records had not been incorporated with previous records. The variables that were examined were the number of admissions, the longest stay for one admission, the total bed days for all admissions, the average days per admission and the length of stay during the last admission. During this time period 112 patients were in the group that would have been classified as terminal. Of these 102 were examined. The remaining 10 were records from patients residing outside the normal geographic boundaries serviced by the MEDCEN who had been transported in from another military Medical Treatment Facility. This left 91.1 percent of the terminally classified patients from the immediate Fitzsimons geographic area. It was determined that the mean for hospital admissions was 3.9 with the mean of the longest stay being 39.5. The standard deviation for these two variables were 2.89 and 31.2, respectively. The mean for total hospital days was 66.9 with a standard deviation of 49.75. The average number of days spent for each admission was 22.5 with a standard deviation of 22.3. The last admission

had a mean of 20.7 and a standard deviation of 23.8. Additional descriptive statistics were looked at and are summarized in Appendix 1. Various statistical techniques were used to manipulate the data to see if any significant relationships were readily apparent. The relationships between any one variable and another showed coefficients of variability in the 50-75 percent range indicating no significant relation. (For possible interest, though not especially relevant to this paper, a printout summarizing the information obtained using SPSS is attached as Appendix 2.) A summary of this data would indicate that there were 141 patients who died in the last 18 months who might have benefitted from hospice care. This does not include patients who, over the last 18 months, may have been classified as terminal but who have yet not succumbed to their disease process.

Research Question

Assuming that there is a need for hospice service, what is the best model for the military to adopt to provide this type of care?

Definitions

Hospice - A hospice is a program concentrating on the care of the terminally ill and their families. It can be exclusively inpatient, exclusively outpatient, or some combination of both inpatient and outpatient. It involves an interdisciplinary approach provided by clinical and nonclinical professionals, staff members or

volunteers interested in alleviating pain and assisting the patient and family to cope with impending death.[12]

Significant Compliance - Significant compliance is a phrase used by the JCAH to indicate that there is evidence an institution is taking action to meet the intent of a standard and that the institution should be in compliance within the next two months.[13]

Substantial Compliance - Substantial compliance is a phrase used by the JCAH to indicate that an institution has met the intent of a specific standard.[14]

Relevant Facts

1. The service area of Fitzsimons Army Medical Center includes approximately 55,000 beneficiaries of military medical benefits.

2. There are approximately 170-220 individuals who are diagnosed as suffering from a terminal illness every year at Fitzsimons Army Medical Center. Of these, approximately 100 are from the local geographic area, the rest being within our service area and are referred to FAMC from other military Medical Treatment Facilities. These individuals are suffering primarily from various forms of cancer or from end-stage renal failure.

3. The accreditation by the Joint Commission on Accreditation of Hospitals is important to The Surgeon General's Office. The need to strive for accredited status in any project is therefore classed in this study as a fact and not as an assumption.

4. Only one documentable attempt at a military hospice

model has been found in search of current literature or through current contacts. This hospice model was attempted at Fort Leonard Wood, Missouri. The model was disapproved by General Leonard Wood Community Hospital's higher headquarters, Health Services Command.

5. Currently CHAMPUS is undergoing financial difficulties resulting from having exceeded its budgetary limitations. This fact is necessary in light of an assumption that will be made.

6. The Denver Veterans Administration Hospital is currently developing and working with their own hospice model. This fact is also necessary to support an assumption that will be made.

Objectives

1. Conduct a thorough literature review.

2. Establish the mode of care delivery that will be utilized by the hospice. There are three possible modes that might be used. Individuals who are designated as a portion of the hospice staff might treat patients only on an outpatient basis or they might treat them only on an inpatient basis. The third mode of health care delivery would be to have those individuals designated as hospice staff working with the terminally ill patient while that person is able to be in an outpatient status and then in the final portion of the person's illness work with them as an inpatient. This would give, then, an outpatient only mode, an inpatient only mode, or a combination

outpatient/inpatient mode.

3. Determine the optimal staffing mix of clinical and nonclinical professional personnel to provide for the needs of the patient/family.

4. Construct a hospice model utilizing the staffing developed in objective three to deliver the mode of care provided in objective two that will adhere, as much as is regulatorily possible, to the standards that the JCAH has proposed on hospice accreditation.[15]

Criteria

The criteria that must be met in order to accomplish the objectives that have been given are closely related to the standards for accreditation of hospice programs proposed by the JCAH. This relates back to the fact that The Surgeon General's Office has been a strong supporter of accreditation. In concert with this, the following criteria, if met, will support not only the JCAH goals but will meet objectives two, three, and four. Alternative approaches that will meet a specific criterion will be weighed and the one most consistent with current military medical practice and JCAH standards will be chosen.

1. Both the patient and his family will be treated as a single care unit with basic rights.

a. The hospice program should have to have a written admission criteria that reflects the patient-family's desire and documented need for hospice services.

b. The hospice program should develop a health care

plan for each patient-family unit.

2. Basic human needs should be met by the mode of health care delivery and by the clinical and nonclinical professional staff members who make up the hospice program. These services shall include, but not be limited to, the following:

a. Grief counseling/bereavement services.

b. Clinical medical care (nursing and physician services).

c. Social work support services.

d. Spiritually supportive services.

e. Voluntary services provided by volunteer members.

3. Any care that is provided by any team member will be documented in the patient medical record.

4. The staff members proposed in the model will have ready access to spiritual/emotional support on a continuing basis. The model will have provisions to document this support.

5. Pain and symptom management will be addressed in the model and provision will be made for documentation of this management.

6. Continuity of care should be documentable in the mode of care selected.

7. The model should specifically address the needs of an accurate medical record, the administration/governance of the model, personnel policies and procedures, utilization review and quality assurance.

a. The model should provide for utilization of standard inpatient or outpatient medical treatment facility medical records, whichever is appropriate for the mode of health care delivery that is selected.

b. The administration/governance of the hospice model should be compatible with current military medical organization, much as a clinic, and must be addressed and documented in the model.

c. The personnel policies and procedures of the hospice model should be addressed and not differ from those that are documented for other staff members of the military medical treatment facility.

d. The model should have a utilization review and a quality assurance program.

8. The cost of maintenance of a "typical" hospice patient will compare (equal to or less than) favorably with current inpatient care.

Assumptions

1. In examining the criteria that have been presented one best mode of health care delivery as mentioned in objective two should surface as the best model for the provision of hospice type care. If this is not the case, additional alternatives will be developed. The population that is served by Fitzsimons in the immediate geographic area will remain basically unchanged at 55,000.

2. The approximate number of individuals determined to

be terminally ill will not vary significantly from 170-220 terminal cases per year. Those in the immediate geographic area will number approximately 100 per year.

3. Due to budgetary limitations this type service will not be available through CHAMPUS.

4. Individuals who are qualified to be beneficiaries of the Veterans Administration will be able to obtain hospice type care from the Veterans Administration and will do so.

Limitations

The development of the model is based on information obtained primarily from Fitzsimons Army Medical Center. Limitations as to the types of care that may be provided are given in AR 40-3 which makes no provision for hospice care. It does not, however, preclude such care if it is established in the proper format. Additionally, Title X of the US Code, Section 1077(B) lists both domicilial and custodial care as outside the type of health care that may be provided to military medical beneficiaries. Specifically domiciliary or home care will not be provided to anyone other than active duty members who will be medically fit to return to duty within 12 to 15 months. This would obviously exclude this type of care for the terminally ill active duty member or any non-active duty beneficiary.[16] This is a limitation that does not preclude the establishment of a properly constructed hospice model. Current CHAMPUS regulations exclude custodial care, domiciliary care in an institution and other related services.[17] One further limitation will be that

the model will be developed following JCAH proposed standards and will not constitute a radical, new departure from accepted practice but rather a model tailored for military medical treatment use based on both patient data and cost data.

Literature Review

An initial review of literature involving death, dying and grief was conducted. A more thorough review of the current literature directed at specific functional types of hospice models was completed as the first step in developing a military treatment facility hospice model. With the completion of this literature review objective number one was satisfied. A rather extensive bibliography was developed and is included with this paper. The length of this bibliography was to be exhaustive of the more recent holdings at Fitzsimons Army Medical Center and was prepared, primarily, to help other individuals at FAMC who had an active interest in hospice type care obtain information quickly and easily. The length is therefore purposeful and not there solely for length's sake. It is interesting to note that a great deal of unpublished material is available from various sources such as the Veterans Administration and various hospice organizations that would aid an individual in the establishment of a hospice program or a hospice model.

Research Methodology

Critical to the establishment of a hospice model are objectives two and three. In order to establish the mode of health care delivery, consultation with staff members will be necessary

to arrive at strengths and weaknesses of each of the three mentioned modes. Staff suggestions on each mode of health care delivery will be examined in light of the JCAH proposed standards and military regulations. After a mode of health care delivery has been established, the optimal mix of personnel can be determined utilizing the JCAH standards, regulatory requirements, and cost-benefit analysis. Terminally ill patients differ in the care regiments that they require. Utilizing the professional opinions of those on the staff that were consulted to develop the mode of care, a profile of what might be considered a typical terminally ill patient will be developed for cost-benefit analysis. The cost of the health care regiment that the terminally ill patient receives will be compared to the costs that are presently incurred utilizing the existing, primarily inpatient care such an individual receives. A discussion of the intangible benefits to both the patient and the family of the patient will be presented. Evaluation of these intangible benefits will be somewhat subjective, however, and consultation with the professional staff will again be sought. The establishment of the mode of care and staffing requirements will allow for development of the hospice model.

II. DISCUSSION

Mode of Health Care Delivery

Within current literature there are many modes of hospice care that are mentioned. Five different models are the wholly volunteer program, home care services, free-standing institutions, hospital based palliative care units, and continuum-of-care subacute facilities are the most commonly described.[18] Tne characteristics of these five models, however, can be distilled into three basic health care delivery modes. These modes are outpatient care, inpatient care, or a combination of outpatient and inpatient care.

Mode of Health Care Delivery: Outpatient

The outpatient mode involves patient clinic visits and hospice home care. While the patient is well enough, visits to an outpatient type clinic environment would be conducted. Clinic visits would consist of counselling by various health care professionals who could provide supportive care that the patient would need to alleviate pain and symptoms. When the patient's condition deteriorated in such a way that no further benefit could be obtained from visits to a hospice clinic, then the clinic personnel would visit the patient in a home care setting.

An extremely important element of this type of outpatient care is the patient's family. In most cases they will be required to provide the routine nursing to ensure the patient's comfort.[19] Many patients requiring treatment that is usually considered extensive or skilled nursing, such as intramuscular injections, rectal suppositories, irrigation of a colostomy, tube feedings, or even suctioning of secretions, can receive this care at home through the efforts of family members. Normally, such relatively sophisticated nursing care is taught to family members both at the outpatient counselling sessions and by a home care nurse who visits with the patient and the family at regular intervals.[20] The primary advantage to this type of care is that the patient remains in familiar surroundings with loved ones to help with the adjustment to the psychological and physiological adjustments that have to be made when confronting a terminal condition. The outpatient form of care utilizing clinic visits and home visits requires that the patient have a strong and supportive family who is willing and able to provide the hands-on nursing care that is needed.[21] This can present a distinct disadvantage. If the eligible military beneficiary does not have a family member or significant other who is able and willing to help participate in the care, then no amount of home care visits can sufficiently replace inpatient hospitalization. Very often, even if capable family members are available, there will come a time when the patient can no longer be adequately supported on a home care program. With the goal of the hospice to be the relief of

suffering, certain conditions will not allow the patient to be comfortable and pain free at home. In the outpatient care only mode, if this stage is reached, the patient must leave the care environment which has become familiar and enter a hospital for routine inpatient support. This presents additional disadvantages. The primary disadvantage is the loss of continuity and coordination of care by the hospice team.[22] The other main disadvantage is that most hospital rules preclude the close family contact that hospice programs normally emphasize. In such a case the patient is returned to an alien environment where individuals untrained in the niceties of hospice care may very well ignore, to some extent, the terminal patient. The rigid rules and regulations often make the terminal patient feel uncomfortable in what seems to be an alien environment after the outpatient treatment course. This adds extra stress to an individual who is already under a great deal of stress.

The outpatient mode of hospice care requires a great deal of interdisciplinary cooperation among various health care professionals. In order to free the patient of pain, to alleviate disabling symptoms, to provide proper nutrition, and to ensure comfort, a coordinated effort by a well structured multidisciplinary team is required.[23] This is expert intensive, but is usually cheaper costing $55.00 or less in the civilian community per day as opposed to inpatient costs of well over $200.00 per day and on their way up.[24] As various team members work with the patient and family as a single care unit in the outpatient mode, an intense bonding often occurs. The staff's

primary aim or interest is to meet this one health care unit's needs in whatever way they can, be it spiritual, physical or psycho-emotional. The team tries to help patients achieve the level of self-care and independence that they need to live as full and productive a life as they may prior to death. The outpatient mode is very similar to the other modes of care in this respect. If the amount of care that is given becomes too intense, however, and too many visits by staff are made, then a violation of AR 40-3 could be construed to have occurred. The care provided at home must be of a nature that the family and the patient provide the care and are the primary source of that care as opposed to having the staff consultants furnish the majority of hands-on care.

Mode of Health Care Delivery: Inpatient

Inpatient care is not much of a departure from normal military medicine that is presently practiced. The primary difference is that the terminal condition of the patient is recognized and that all the care that is given is aimed at making the patient comfortable and not attempting to cure the patient. This greatly reduces the stress that the individual patient feels and additionally, alleviates some of the concern that hospital staff members feel when they see that they cannot provide a cure for a particular patient. The feeling that the staff member has that he has failed when no cure can be effected and a patient dies is avoided when a patient is placed in an inpatient mode of hospice care where individual staff members have received proper

training. The criteria for admission to a program such as this are somewhat more strict than for the outpatient mode of health care delivery. Here the physician must make a direct admission of the patient to the hospice. In most programs the patient must have only a short time before death is expected and home care must not be a viable option. This may be because the patient has no family member capable of providing the care or the routine types of care might require certain nursing skills such as colostomy maintenance or IV medication which is beyond either the patient or the patient's family or significant others. In this type of a inpatient only mode of care, little or no contact has been made with the patient by the hospice team of care providers until the patient is formally admitted to the hospice.[25] If this form of care is provided during a very brief, final stage, no significant problems with either regulations or public law will prevent incorporation and utilization of this form of care delivery. The primary advantage of this form of hospice program is that it can provide care by trained and concerned staff members who will not ignore the patient and who will help to keep the patient as symtom free as possible. Here again differences are readily apparent between routine inpatient hospitalization and hospice care. The feeling of abandonment that often comes in routine hospital admission of a terminally ill patient is not normally present in the inpatient hospice environment. If a patient is bed confined, efforts are usually made to make a bright, cheery environment with more than the usual amount of room and

space for some personal belongings. This leads to a feeling of belonging and a sense in the patient that the staff is caring.[26] As with the outpatient mode of hospice care, the inpatient mode relies on a team of specialists. The difference is that normally these individuals see patients other than hospice members. This is especially true of those specialists such as occupational therapists, physical therapists, and clinical dietitians. Other team members such as clinical nursing specialists, medical directors, social workers and psychiatrists may work exclusively for the inpatient hospice. A primary difference between inpatient hospice and inpatient hospital care is that no attempt is made to "cure" the patient. It is understood by both patient and staff that the condition the patient is suffering from is terminal and that the patient has chosen not to receive further therapeutic measures aimed at effecting a cure.[27] This can lead to cost savings in that expensive treatments such as radiation or chemotherapy may be avoided while essentially the same inpatient per day costs are being generated. If the hospice unit is located within an acute care facility in a civilian community, the patient will incur a share of all the ancillary services and facilities even if they are not used.[28]

The primary advantage of the inpatient mode is that an existing staff of health care professionals representing a wide range of disciplines may be made available at no significant increase in cost. The primary disadvantages of this mode of treatment in a military setting is that care must be taken so

that violations of regulations prohibiting domiciliary care or custodial care do not occur. With an inpatient only mode of health care delivery continuity of service to the patient is usually lacking. An additional factor that affects this type of health care delivery, more perhaps than the outpatient only mode, is that there is a specific prohibition against writing no code orders in a patient's chart within an Army Medical Treatment Facility. This policy was established by a first indorsement commenting on the Texas Natural Death Act written by MG Enriques Mendez who, at the time (May 1968), was Acting The Surgeon General for the United States Army.[29]

Mode of Health Care Delivery: Outpatient/Inpatient

The other mode of health care delivery is a combination of the two modes mentioned above. This mode, the outpatient/inpatient mode, combines the advantages of both of the previously mentioned modes and avoids several of the most significant disadvantages. This mode allows for a patient-family home care for as long as it is possible for the patient to be maintained with only consultative type visits from hospice home care team members. If the time comes when the patient is no longer able to be adequately cared for at home, the patient is admitted to the hospice unit, either free-standing or inside an acute care facility for final care. In nearly every case the patient will be facing imminent death at the time of this transfer. This will avoid any conflict with AR 40-3 but will still provide continuity of care in a coordinated manner. A properly structured hospice

model would have available all those ancillary services that the medical director of the hospice might find necessary in the manangement of an individual case. If, for instance, the patient required speech therapy due to a mass having been excised from the mouth or throat, the services of a speech therapist would be more likely available in an outpatient/inpatient mode than in an outpatient only mode. Other specialists such as the occupational therapist, physical therapist, clinical dietitian and even financial and legal aid representatives could be more easily available because their services would be spread to not only the hospice type patient but the other inpatients. One disadvantage would still remain. This would be the prohibition against entering no code information in a patient's chart. While this currently presents a problem due to the afore cited policy put forth by MG Mendez and supported further in DA Pamphlet 27-50-69, Paragraph 8, pages 29 and 30, there is hope this may soon be changed. In a letter by COL James G. Zimmerley, Chairman of the Department of Legal Medicine, Armed Forces Institute of Pathology, an opinion was expressed that the current policy has caused confusion and that state directives such as the Texas Natural Death Act should be honored.[30]

Since the outpatient/inpatient mode seems to incorporate the advantages of both of the other health care modes, it would seem logical that this mode of health care delivery would be the one selected in the development of any hospice care model. In many instances, however, inadequate numbers of individuals

equipped to provide the specialized care needed might preclude an outpatient mode of care even though an inpatient mode could be attempted. Conversely, adequate numbers of health care providers might be available, both on the staff or in the community who would be willing to serve as volunteers but insufficient room in the actual health care facility itself might prevent the inpatient portion from being used. At FAMC neither of these limitations exist. There currently is adequate staffing available for any of the three modes and there is room in the Medical Treatment Facility for the inpatient mode of health care delivery. (This is based on the reduction of inpatient beds occupied that would occur if a hospice were started.) Consultation with staff members stressed a recurring theme, continuity of care. It was felt by the majority of the staff members that the most important element for the successful operation of any type of a hospice model is the early establishment of a good patient and family rapport with the hospice staff members and a natural transition through outpatient care, involving both clinic visits and home consultation, into an inpatient environment if the inpatient environment was good. As a goal or standard of the JCAH hospice project, a hospice program, to achieve substantial compliance with the goal, should provide a continuum of home care and inpatient care services.[31] This would lean heavily toward the outpatient/inpatient mode of health care delivery. Properly structured, a model for hospice care can provide both outpatient and inpatient care and not violate the provisions of AR 40-3 or

Title X. FAMC has the staff available and the space available in the Medical Treatment Facility to provide both an outpatient and inpatient mode of health care delivery. In light of the staff suggestions and the goal as stated by the JCAH, a hospice model to serve FAMC should utilize the outpatient/inpatient mode of health care delivery.

Staffing Requirements/Costs

The staffing requirements for a hospice to provide care in an inpatient/outpatient care mode will require individuals with skills in a great number of disciplines. The physician in a hospice program is the source of direction for the program. This does not mean that the program is supervised or controlled necessarily by a physician. It does mean that a participating physician will have charge of the medical treatment of the patient doing the initial interview with the patient and the family, the physical examination, recommendation for inclusion in the hospice program, monitoring of the symptoms, control and prescribing the medication required to alleviate pain, and serving as the source of medical knowledge for both the family and staff. One of the most popular forms of staffing is a physician directed, nurse coordinated staff that includes most other types of health care professionals.[32]

Not every individual case will require every individual discipline. A list of skills that should be available for use by the hospice would include physicians with training in hematology/oncology, internal medicine or psychiatry, nurses who have training in oncology care, home care, nursing care administration or

community health nursing. Other individuals who could contribute markedly to the provision of hospice care would include clinical dietitians, pharmacists with experience in oncology and the medication titration required by oncology patients, physical therapists, occupational therapists, social workers, clergymen, and individuals able to give legal assistance and advice on financial matters. Home health care technicians and other paraprofessionals as well as volunteers, both professional and non-professional, can add immeasurably to the structure and success of a hospice care program. It was felt by many of the staff who were consulted to determine what skills were needed, that any skill that is represented in a MEDCEN should be available if needed to provide hospice care. Most of the staff members stated that they would hope to have volunteers from each area so that the whole spectrum of patient needs might be met. This does not, however, provide for any structure to the staffing, nor does it aid in determining the optimal mix of personnel to best work in a military hospice environment. It was felt by most that a gradual phasing of hospice development might yield the best mix of staffing. To accomplish this end it was suggested by several that in developing the actual model, the types of services to be provided should be definitely established. After these were established, a small planning group would arrange for the development of specific interdisciplinary teams and provide for the direction of both the outpatient and inpatient hospice care. Excellent guidance has been provided by the JCAH draft of standards that

spell out what they consider a minimum level of services that should be provided to achieve significant or substantial compliance. These services include physician services, nursing services, bereavement services, psycho-social support services, spiritual services and volunteer services, as well as any other services that are deemed necessary for the proper care of the patient-family care unit.[33] It is recognized that an effort will be made to comply with the goals that have been established by the JCAH. No military regulatory requirements are made concerning staffing for this type of care as this is a new area that has yet to be addressed by regulations. Staffing recommendations in the current literature vary greatly. Most of the references deal with staffing for the individual case. It is stressed that 24 hour care should be the goal for both the outpatient mode and inpatient mode of health care delivery. In one reference the home health care nurse made an initial two hour visit with a patient and his family to ascertain the interaction between the patient and family members and then subsequent visits lasting anywhere from one-half an hour to six hours depending on the patient and family's needs. Each patient was seen at least weekly.[34] Because needs are so very individualistic, the actual size of a program is often dictated by the needs of the individual patients that are admitted to the program. Staffing then follows the size of the program. Due to the difficulty in stating in exact and quantifiable terms the staffing ratios that will be required, it is perhaps best to attempt a view of what a

"typical" patient might require. Various staff members that were consulted agreed that a 56 to 58 year old white male with oat cell carcinoma of the lung might be classed as a "typical" patient. Using current practices this patient would be hospitalized four times with a longest stay of 39 days. His total hospital days would be 67 days and his last hospital stay would be approximately 22 days. Based on costs obtained from Fitzsimons Army Medical Center Uniform Chart of Accounts data, this individual would generate $11,816 worth of expense based on a total expense of $176.36 a day. If, as is often the case, this individual's last stay was split roughly between the medical intensive care unit and regular ward care, the individual would generate expenses in excess of $18,270. This is in light of a daily expense of $893.66 in the medical intensive care unit. These costs figures reflect direct costs and purified expenses plus indirect costs and ancillary costs per occupied bed day. The breakdown of these costs can be seen in Appendix 3. The staff felt that the total hospital stay for a person electing hospice care would normally be much less than what would be experienced by a person selecting routine curative care. In the case of our patient who would have up to 67 hospital days, a total of 14 days was projected, none of these being in the MICU. This would include approximately four days during the initial evaluation period where a medication regiment would be established. After this initial four days, the individual would be discharged to a home care program and would return only when

death was imminent. It was felt by most of the staff that a value of approximately half the current last hospitalization stay could be expected as the final hospitalization stay for a patient in a well run, well structured hospice program. This would give us an additional ten days for a total expense of $2,469.00. This would require normal staffing patterns that are currently being used on the wards. It is felt that this would be a realistic value including not only patient care items such as expendable supplies, tissues, linens and so forth, but also staff salaries. In addition to the last 14 days over the normal course of a disease such as oat cell carcinoma of the lung, there would be a requirement of one visit to the clinic every other week on an outpatient basis for the first two months of the outpatient course, thereafter for the next two months one visit a week and in the final two months only home care visits by nursing staff. The clinic visits would occupy 12 hours of physician time. This would contribute a cost of approximately $327.00 for a board certified Lieutenant Colonel with ten or more years of service.

Nursing visits would require a minimum of a two hour initial visit and a minimum of one hour per week after that. This would give a total of seven hours of home care nursing. Most staff members thought that this was somewhat unrealistic and that approximately ten hours' worth of home visits could be anticipated. For a nurse with approximately eight years in the service this would equate to approximately $205.00. (Travel time within the local area was taken into consideration at arriving at

this figure. It is felt that most instances during a day where routine visits would be accomplished that from five to seven visits could be accomplished in one day.) For basic physician and nursing services plus the expense for the 14 days' hospitalization the amount of expense would be $3,001.00. These, however, would not be the only expenses that would be generated. It is felt that our "typical" patient would require the services of the oncology pharmacist for the period of approximately one hour in establishing the titration of his home care analgesic and an additional one hour monitoring the pharmaceutical regiment over the course of the patient's disease. This would generate another $31.00 worth of expense. A dietitian would probably be consulted for a period of approximately one hour. A social worker would help evaluate the patient and the family initially and would require approximately four contact hours. The most significant personal involvement with the patient and family would probably come via the chaplain. It was felt that an initial counselling period of two hours followed by weekly counselling periods of approximately one hour per week for the first four months of the disease course and then on an as needed basis during the last two weeks and during the hospitalization period generating another 20 hours. The contact of the chaplain would not end at this point. An additional four contact hours in helping the family to arrange for funeral services and in bereavement counselling would likely be required. Approximately two additional social work hours would also be spent during the bereavement counselling. Contact

with the family at two weeks, two months and six months would be recommended. Total patient care costs for our "typical" patient would be $3,745.00. This figure places no value on the work of volunteers. It is expected that in any strong hospice program that there will be approximately a four-to-one ratio staff to volunteer hours. For our "typical" patient this would equate to roughly 18 hours of volunteer service. This services would include such things as helping with shopping, visiting, and just calling up and chatting on the telephone. For our patient no costs were included for occupational therapy or physical therapy. In many cases these services would not be utilized but it improves the stance of any program to have these services available if needed. The difference in costs is quite large. With an approximate cost difference of $14,527.00, not only is a significant amount of money not spent on this patient if in a hospice, but the patient receives the benefits of being able to stay home for an extended period of time and being cared for in a familiar setting. Additionally, there is structured support emotionally and physically for his family. The mode of staffing would reflect physician direction and nurse staffing to meet the requirements of the patient's every day existence. Ancillary health care professionals would be called upon on an as needed basis. The optimal patient care staffing mix would then require a physician as the head of the hospice care team with a visiting nurse to provide the home care and then specialized oncology nurses available to provide the inpatient hospice coverage. It

is felt that any requirements that a home care patient might have that would occur after normal duty hours could be handled very well by the inpatient hospice nurses. A phone call to the hospice inpatient unit would easily result in the patient receiving the advice or the consultation that was required. On rare occasions, a home visit might need to be made after normal duty hours. This could be accomplished on an on-call basis. The home care nursing duties should rotate but a nurse should try to follow a patient from their entry into the program until their death. This would provide continuity of care.

Since care will be on an individualized basis, an optimal mix of health care providers for every individual case cannot be clearly established in advance. It was recommended, however, by most of the staff that was consulted, that a physician led team be established for each patient. Each of the teams would be coordinated by a hospice care coordinator who would take care of administrative details as well as nurse scheduling. This individual would normally be either a nurse or an administrator. The director of the hospice unit might be from any discipline, though in the Army setting the logical choice would be a physician. Several physicians did mention that they thought a chaplain or a social worker would be an excellent choice for director of hospice care with a medical director appointed by the Chief of Professional Services. Utilizing extremely flexible staffing having a physician directed team, a hospice model can be constructed.

The Hospice Model: Basic Requirements

There are certain basic characteristics a hospice program should contain. These seem to be fairly well established in the literature. Some of these characteristics are that a hospice program should strive to be autonomous, be centrally administered and be a program coordinating out and inpatient services, primarily concerned with home care but with adequately staff backup inpatient services when home care is no longer feasible. Central to the program is the concept of a primary care unit which is the patient and the family. It is realized that total patient care includes dealing with the family or significant others. Once a patient has entered a hospice, symptom control is the primary goal. The symptoms may be physical, emotional or spiritual. Physical symptoms include pain, nausea, or vomiting or any other physical discomfort that can usually be adequately controlled by medication. Emotional symptoms involve such things as distress, anxiety, or denial and may be lessened by individuals properly trained in behavioral sciences or counselling. Within our military structure both social workers and chaplains function adequately in these roles. The last type of symptom control is spiritual and can usually be handled quite adequately by the chaplain's staff. Another important characteristic of a good hospice program is the interdisciplinary care concept. Health care is provided under the direction of a physician while ancillary support is provided by social workers, physical therapists, occupational therapists, clinical dietitians,

chaplains and any specialist whose services are deemed necessary. Volunteers make up an especially important segment of the good hospice program. Their mission is to augment staff services, not take the place of trained staff. Volunteers often provide services that clinical personnel cannot or do not have the time to perform such as basic companionship, help in recreation, helping with shopping or other necessary functions. An especially important portion of a good hospice program is bereavement follow-up. After the death of the terminally ill patient, the family is provided assistance during a period of bereavement. Follow-up checking on the patient's family is conducted by nursing, social work and the chaplain's staff. A hospice should be functioning and available around the clock, seven days a week as needed. As important as all the services to the patient/family units are, it is extremely vital that the staff have support and assistance to handle the grief and to cope with the problems that caring for the terminally ill can present.[35] These characteristics are fairly basic but not every hospice will manage to incorporate each of these characteristics. The hospice should be designed to care for the patient population that it serves. In establishing a model for Fitzsimons and for consideration by other Military Treatment Facilities certain basic criteria should be met by a patient prior to admission to a hospice program. The patient must have been diagnosed as having a terminal disease of relatively short duration. In the different cases that were examined from Fitzsimons, initial entry into

the program might be as long as two years prior to death. The patient must have family members or significant others who are willing to assist in home care if this is required. Both the patient-family unit and the attending physician must agree that further curative procedures are of no value and that the patient-family unit desires the services that may be provided by the hospice program. It is understood that a patient or the patient-family unit may withdraw from the hospice program at any time. Reversals have been known to occur. Individuals who have been pronounced terminally ill have made startling recoveries. While this occurrence may be extremely rare, every unexpected improvement must be exploited to its fullest. Patients therefore must have a clear route back to the curative care system if this becomes appropriate.[36]

The Hospice Model: Organizational Structure

An effectively operated hospice program requires some type of coordinating body plus actual health care teams in order to function properly. Several of the civilian programs utilize a board of directors similar to the form of governance that is common for a hospital.[37] In the federal sector both the Veterans Administration and the one hospice that has been attempted in the Army have provided for a coordinating committee.[38, 39] The function of these committees is to handle the administrative matters and provide some guidance for another group made up of the actual providers--the hospice care team. The coordinating committee would be composed of physicians and

administrators as well as representatives from nursing, the chaplains and any others that it was deemed appropriate to have. The actual hospice care team would be made up of the medical director (a physician), the hospice care coordinator (a nurse), and representatives from all the ancillary services such as clinical dietetics, social work, occupational therapy, physical therapy, chaplain and others that were deemed necessary to provide the care that could possibly be required by patients in the hospice. Team members would be responsible for the training of new members and to help other current team members cope with the stresses associated with hospice care. By its very nature it is important that each individual who is working with the hospice program be a volunteer to that program. Actual operation and management decisions are much more participative than would normally be the case. This is because there is no monopoly on good ideas. If an idea may be used, it should be if it improves the care that the patient receives. The health care team would normally coordinate the assignment of specific individuals to specific patients.

The Hospice Model: Patient-Family Care Unit

For the hospice concept to function properly the patient and his family or significant others must be treated as a single care unit. Within this goal should be the attempt to discuss completely all matters that will affect patient care. Throughout the establishment of a hospice program it will be necessary to document all patient related activities. This can start with the

primary interviews with the patient-family unit. The patient and his family should be well informed of their rights. They should be allowed to freely ask any questions about the program so they may be put at ease about the goals of the program and the services that the program attempts to offer. A review of the criteria for admission should be one of the first activities accomplished during the initial meeting between the hospice and the prospective care unit. The criteria, as given above, would reflect that a patient must be assessed to be terminally ill, he must desire hospice care and he must have family or significant others who support him in this decision and will assist in the provision of much of the home nursing care. Admission forms similar to those used as surgical consent forms listing the admission criteria and the goals of the hospice should be signed by both the patient and the patient's family. It is extremely important that the attending physician, if the physician is intending to participate, be present at the first counselling session. At this time, the admitting physician, if he is going to be the attending physician, or a hospice physician who plans to assume the attending duties, should be present along with the home nursing care coordinator and perhaps a chaplain or social worker and an administrator. These individuals will help assess the family-patient situation and will develop a preliminary health care plan for this patient-family unit. This, as with everything else, should be adequately documented and explained to the patient-family unit. At this time individual members who will be

assisting in the treatment of this unit, if available, should be introduced to the patient and his family. The patient should clearly understand the services that are available. They should realize there will be three types of symptoms; emotional, spiritual as well as physical. They should be informed that there are chaplains and social workers available to help with coping and that every effort will be made to take care of the family's emotional problems and acceptance of grief and, after the patient's death, bereavement. Basic clinical medical care will be provided by trained nursing staff in a home care environment for as long as possible. Physician services will always be available to provide assistance in determining the proper medication to handle pain. Additional social work support services will be available on an as needed basis. This will include counselling to assist in adapting, acceptance, and coping with the situation the family finds itself in. The social work counselors will often have to assist the dying patients to go through the classical five stages of death: denial, rage or anger, bargaining, depression and finally acceptance.[40] In this task the social worker may be assisted by clergymen. It is important for the patient-family care unit to come to a clear understanding of their spiritual beliefs. Some families will have very weak or no spiritual belief and they should not be forced into an uncomfortable situation if this is the case. There should be a wide variety of chaplain assistance available, however, for those who have firm spiritual beliefs and require

counseling of this nature. Many volunteer services can be provided by such agencies as the Army Community Service and the American Red Cross. These volunteers can provide such amenities as helping the patient to go to the beauty shop or the barber, assisting the individual or family with grocery shopping, providing transportation, or any of a hundred other services. All care or assistance by any team member should be adequately documented.

The management of pain is a very vital part of an adequately run hospice program. Every effort should be made to involve a pharmacist with a good deal of oncology experience to help titrate the analgesic prescribed by the patient's attending physician, against the pain. The proposed level of analgesic activity should be that which will leave the patient pain free but clear headed.[41] It is extremely important that this care be documented so that the physician may draw upon past experience to help the pharmacist arrive at a proper level or dosage as quickly as possible. This will prevent needless experimentation during the titration phase.

Since continuity of care is extremely important for the emotional stability and well being of the patient, every attempt should be made to provide a particular patient's care by the same team. As the patient grows to know and trust his team, the success at getting the patient to follow instructions will greatly improve the quality of care. Every attempt should be made to document this continuity of care. The patient record will be

made up of the standard forms that are currently utilized by the Army. This should greatly facilitate the obtaining of forms and the training of individuals in their use. This should improve the accuracy of the medical record and its usefulness in treatment of the patient.

The Hospice Model: Staff Members

Staff members for the hospice program should all be credentialed for the level of care that they are to provide. The physician staff should be credentialed in the same manner and for the same privileges as they would be in any military Medical Treatment Facility. Nursing member credentials as well as the credentials of the clinical dietitians, occupational therapists, social workers, physical therapists, pharmacists and others should be the same as for any Medical Treatment Facility in the military service. General control of each patient plan will be under the supervision of the hospice team leader who will be a physician. The health care coordinator will insure that procedures that are applied to any patient are well documented. Inclusion of any health care professional to assist in the treatment of a particular patient will be done in such a manner as to insure that the patient is not receiving redundant or unnessary care. The hospice medical director and nursing care coordinator as well as the attending physician will review the patient's chart weekly to insure that only that care which is necessary is being delivered and that the patient is receiving all the care that is necessary. The records of the patients will

further be monitored by the Utilization Review and Quality Assurance Committee of the hospital. This will involve the selection of a minimum of 10 percent of the records monthly for a complete audit by the Quality Assurance Committee. Both concurrent and retrospective reviews for proper utilization will be conducted. The goal of the Quality Assurance Program will be to enhance the patient-family care. The Quality Assurance Program will address each of the services such as bereavement service, physician service, home care services that are provided to the patient. Any unusual instance will be reported to the hospice care committee. The model provides for significantly reduced costs as can be seen Appendix 4. Within this Appendix are the estimated costs for hospice care for three particular types of terminal illnesses that have been encountered at FAMC. Actual hospitalization times that occurred in these patients are used to compute the dollar amount that these illnesses cost. Estimates based on the number of clinical visits and the number of home care visits have been generated by discussions with staff members and have been somewhat inflated due to the possibility of overly optimistic projections being given by staff members.

III. CONCLUSIONS AND RECOMMENDATIONS

Based on the discussions held with staff members and review of the literature plus the active programs in the metropolitan Denver area as well as the program being conducted by the Veterans Administration Medical Center in Denver lead to the conclusion that hospice is a concept whose time has come. Many people have reached the conclusion that curative medicine is not always the answer. There will be many people, classed as terminal, who would abandon the curative mode if an alternative mode of care is offered.

Viewing the various types of programs that have been attempted, there are three types or modes of health care delivery that seem to be prevalent. These modes are the outpatient, the inpatient and the combination outpatient/inpatient modes. In the case of FAMC and most other military Medical Treatment Facilities it is not cheaper just to ignore the hospice concept. Costs for treating terminal illnesses, as well as other types of illnesses, are rising.

In a Medical Treatment Facility, which is also a teaching institution, many procedures are often attempted not only in an effort to benefit the patient but also to teach the young physician. These procedures are often very costly. A great many of them cause physical discomfort and are of very little benefit. In a hospice program most of these curative type procedures would not be attempted.

Looking at the three modes that have been suggested, any

of the three would be more cost effective than straight patient care of the amounts that can be seen by the descriptive statistics that have been provided. The provision of outpatient care by itself without a hospice team that would follow-up when the patient was admitted would lack continuity. It would affect no significant cost savings over the inpatient only mode or the combination outpatient/inpatient mode. In any of the cases reviewed care would have to have been provided and probably would be provided by the more expensive, standard inpatient only non-hospice method such as is presently being used. There is no reason why a military Medical Treatment Facility could not maintain the continuity of care and provide an outpatient/inpatient mode of treatment. The continuity of care would add greatly to the patient's sense of well being. The actual structure, then, would require a hospice committee to provide the governance and the administration of the hospice. This should be composed of a medical director appointed by the Chief of Professional Services or the Commander, a nursing care coordinator, administrative officers and a chaplain and a social worker. The organization of this committee should be such that the individuals work well together and that there is a participative type atmosphere to the meetings that they hold. It is not necessary that the medical director be the individual who is "in charge" of the committee though in most cases this will probably be the most efficient use of personnel resources. The hospice committee will coordinate all administrative aspects of the hospice program as well as advise the hospice

care team portion of the program in administrative and technical aspects of the operation of the hospice program.

The hospice care team should be composed of attending physicians, the nursing care coordinator and home care nurses and all ancillary personnel such as the oncology pharmacist, the occupational therapist, physical therapist, clinical dietitians, volunteers and other individuals who will assist in caring for terminally ill patients and their families. Of primary importance to the hospice care team are the chaplains and social workers who will help the individual team members cope with the stress that caring for terminally ill patients often presents. It would be a great benefit to have a team composed of a psychiatrist, a social worker and a chaplain to help individual hospice team members, and the hospice team as a group, debrief and cope with the strain they are under. It is important that these individuals be allowed to ventilate and express their feelings both in a private setting and a group setting.[42]

Selection of patients is extremely important and should be based on the criteria outlined above. These include having an individual who is classified as terminally ill who wants the program and who has supportive family members to help in his care. To maintain its vitality the hospice care team must provide for training of new members and must have adequate opportunities to participate in educational opportunities offered in the outside community. Volunteers should be utilized to "fill the gaps" between what the families can help the patient with and what the

professional health care providers can furnish.

It is necessary that the provisions of AR 40-3 and the provisions of Title X of the US Code as they relate to domiciliary care not be violated. There is a prohibition against home health care in AR 40-3. This type care will only be provided to active duty members who will be medically fit to return to duty within 12 to 15 months. This is obviously not the case of individuals who enter the hospice. As a result the actual home care will have to be provided by the family members and that the home care nurses provide counselling and training of those individuals during their visits. It is fully recognized that in the last few days of life, when death is imminent, most terminally ill patients will be hospitalized for a period of time. It has been estimated that all but the most extreme cases can be successfully treated at home by willing family members up until the last 10 days of life. It has been further estimated by many staff members that as many as 50 percent of the patients admitted to the program may be able to die at home. This has been borne out in several publications such as the July/August 1978 issue of Cancer magazine where 56.8 percent of the patients admitted to one particular hospice program died at home.[43] Individual care teams should attend, if possible, a particular patient-family unit throughout the course of the disease and care for the family in their bereavement stage. This requires a great deal of personalized attention. It has been estimated that a staff-to-patient ratio of 1:1.25 should be used for planning purposes.[44]

The assets required to establish a hospice at Fitzsimons are already in place. The individuals who could comprise a hospice program committee are available. The individuals who would make up the hospice care team are available. The individual practitioners who would make up the individual patient care teams or sub-teams of the larger hospice care team are available and many have expressed an interest in seeing a hospice program developed. A hospice program can provide definite benefits to the patient who desires this type of program. It's follow-up bereavement services provide a facet of care to the family and therefore the patient which has not yet been established in military Medical Treatment Facilities. The program would add humanity back into the care and treatment of the terminally ill. The emphasis would be on care, not cure.

Recommendations

It is strongly recommended that, in view of the demonstrated need, the interest of the medical center staff, and the substantial asset savings that could be realized, a hospice program be established at Fitzsimons Army Medical Center. The first step in establishing such a program would be the appointment of the hospice program committee. This committee would establish and document the need for such a program, develop the policy letter or regulation that would govern the program, establish a hospice care team, define in writing the duties of the various individuals involved in the hospice care, establish the criteria for admission to the program and, most importantly,

draft the correspondence to Health Services Command requesting permission to establish a pilot program for hospice care. A definite period of time should be established for this pilot project. Results from one year to 18 months should be sufficient to document not only the savings but also the added benefit that individuals can sustain from being cared for in this type of a treatment setting. It is recommended that the JCAH proposed standards be used as guidelines by the hospice program committee to develop the actual hospice program. A copy of these proposed draft standards has been included as Appendix 5. Once the pilot project has been approved and has from one year to 18 months' worth of documentation, approval should be sought from HSC for implementation of a full blown hospice program. It is important from the outset that all individuals who are interested in becoming involved in the hospice care program be adequately trained. Many of the resources required for such training are already available within FAMC. Development of the actual program will not be expensive, requiring only some additional time from those individuals who are appointed on the hospice program committee. Any added expense due to loss staff time could be recouped during the operation of the pilot program. It is recommended that the budget analyst and the management assistance analyst from the Directorate of Resources Management review the estimates for individual cases given that have been made in this paper prior to the beginning of a pilot project. Utilization of Uniform Chart of Accounts and estimates of hospitalization costs

will help to make the cost comparisons and to demonstrate any potential savings. Proper documentation before initiation of the request for the pilot project through Health Services Command should expedite ultimate approval of the program.

The hospice is not intended to be an extended care facility. It is to control pain, provide comfort to both the patient and the family. These are basically intangible benefits of a program. The patient's piece of mind is extremely vital and can be heightened in an environment where he has a feeling that he is contributing to the decisions being made for his care. The hospice care program is a worthwhile and humane method of treating the terminally ill. It takes into consideration not only the patient but the patient's family. It is a great comfort to the terminally ill patient to know that there are individuals who are caring and will assist the family after the patient's death.

APPENDIX 1

Appendix 1

Descriptive Statistics
Source: Fitzsimons Army Medical Center,
Patient Administration Division

Mean number of hospital deaths, 1978-1982: 245.4/year

Time period for study: 18 months, 1 Oct 81 - 31 Mar 83

Total deaths during study time period:	321
Total infant deaths (7 months of age or less):	26
Net deaths studied:	295

Number of deaths classed as terminal patients:	141
Percentage of deaths classed as terminal patients:	47.8%

Table 1
Average Age at Death (Years),
Infants 7 Months and Less Excluded

All Males	59.0	N = 177	60%
All Females	57.6	N = 118	40%
Both Sexes	58.3	N = 295	100%
Terminal, Males	58.7	N = 80	56.7%
Terminal, Females	57.2	N = 61	43.3%
Terminal, Both Sexes	58.1	N = 141	0%

Note: The percentage male to female and the age at time of death does not vary significantly from all deaths to those classed as terminal.

The variables total number of admissions,
longest hospital stay,
total bed days during terminal illness,
average bed days per admission, and
bed days for last admission
were studied from records of terminally ill classed patients who died during the 1 Oct 81 to 31 Dec 82 time frame (this period had mostly complete records while those in the first quarter of CY 1983 were not all complete). Of 112 possible patient records 102 were examined. The remaining 10 were partial records due to the patient being "air evaced" to FAMC or were incomplete for unknown reasons (91.1% of terminally classed records were examined).

Appendix 1 (Continued)

Each variable was examined separately (below) and jointly (Appendix 2).

Table 2
Variable: Total Number of Admissions N = 102

Mean	3.941	Std Err	.287	Std Dev	2.894
Variance	8.373	Kurtosis	6.189	Skewness	2.073
Minimum	1.0	Maximum	18.0	Sum	402.0
C.V. Pct	73.419	.95 C.I.	3.373	To 4.510	

Table 3
Variable: Longest Hospital Stay N = 102

Mean	39.49	Std Err	3.091	Std Dev	31.214
Variance	974.292	Kurtosis	8.777	Skewness	2.445
Minimum	3.0	Maximum	203.0	Sum	4028.0
C.V. Pct	79.042	.95 C.I.	33.359	To 45.621	

Table 4
Variable: Total Bed Days N = 102

Mean	66.863	Std Err	4.926	Std Dev	49.751
Variance	24754.149	Kurtosis	10.358	Skewness	2.409
Minimum	3.0	Maximum	353.0	Sum	6820.0
C.V. Pct	74.407	.95 C.I.	57.091	To 76.635	

Table 5
Variable: Average Bed Days Per Admission N = 102

Mean	22.532	Std Err	2.206	Std Dev	22.275
Variance	496.174	Kurtosis	12.071	Skewness	3.111
Minimum	2.4	Maximum	144.0	Sum	2298.30
C. V. Pct	98.858	.95 C.I.	18.157	To 26.908	

Table 6
Variable: Bed Days for Last Admission N = 102

Mean	20.735	Std Err	2.353	Std Dev	23.761
Variance	564.593	Kurtosis	7.483	Skewness	2.334
Minimum	0	Maximum	144.0	Sum	2115.0
C. V. Pct	114.593	.95 C.I.	16.068	To 25.402	

APPENDIX 2

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             HH      HH  IIIIIIIIII  AAAAAAAAAA  TTTTTTTTTT  TTTTTTTTTT
             HH      HH      II      AA      AA      TT          TT
             HH      HH      II      AA      AA      TT          TT
             HHHHHHHHHH      II      AA      AA      TT          TT
             HHHHHHHHHH      II      AAAAAAAAAA      TT          TT
             HH      HH      II      AAAAAAAAAA      TT          TT
             HH      HH      II      AA      AA      TT          TT
             HH      HH  IIIIIIIIII  AA      AA      TT          TT
             HH      HH  IIIIIIIIII  AA      AA      TT          TT
--EOR--
11
 T
                                                                    83/04/25.    14.36.18.     PAGE    1
          BOULDER DOC LABORATORIES

          S P S S - - STATISTICAL PACKAGE FOR THE SOCIAL SCIENCES

          VERSION 8.3 (NOS) -- MAY 04, 1982

          263700 CM MAXIMUM FIELD LENGTH REQUEST

                    .

                     FILE NAME      HOSPICE DATA 82
                     VARIABLE LIST  VAR001 TO VAR006
                     INPUT MEDIUM   DISK
                     N OF CASES     UNKNOWN
                     INPUT FORMAT   FIXED (F2.0,F3.0,F3.0,F5.1,F3.0,F1.0)


                    ACCORDING TO YOUR INPUT FORMAT, VARIABLES ARE TO BE READ AS FOLLOWS

                    VARIABLE  FORMAT  RECORD    COLUMNS

                    VAR001    F 2. 0      1     1-   2
                    VAR002    F 3. 0      1     3-   5
                    VAR003    F 3. 0      1     6-   8
                    VAR004    F 5. 1      1     9-  13
                    VAR005    F 3. 0      1    14-  16
                    VAR006    F 1. 0      1    17-  17

  THE INPUT FORMAT PROVIDES FOR   6 VARIABLES.    6 WILL BE READ.
  IT PROVIDES FOR  1 RECORDS (*CARDS*) PER CASE.
  A MAXIMUM OF    17 *COLUMNS* ARE USED ON A RECORD.

                     VAR LABELS     VAR001  ADMISSIONS          /VAR002  LONGEST STAY        /
                                    VAR003  TOTAL BED DAYS      /VAR004  AVERAGE DAYS PER ADM/
                                    VAR005  LAST ADMISSION      /VAR006  GENDER
                     PRINT FORMATS  VAR001 (0)/VAR002 (0)/VAR003 (0)/VAR004 (1)/VAR005 (0)/
                                    VAR006 (0)
                     READ INPUT     DATA

  CPU TIME REQUIRED..       .042 SECONDS


  END OF FILE ON FILE FAMDAT
  AFTER READING    102 CASES FROM SUBFILE HOSPICE
1
                                                                    83/04/25.    14.36.18.     PAGE    2
```

```
                CONDESCRIPTIVE VAR001 TO VAR005
                OPTIONS        3
                STATISTICS     ALL

          00036700 CM NEEDED FOR CONDESCRIPTIVE

          OPTION - 1
          IGNORE MISSING VALUE INDICATORS
          (NO MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED)

          OPTION - 3
          WRITE Z SCORES ON BCDOUT
```


FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

VARIABLE VAR001 ADMISSIONS

MEAN	3.941	STD ERR	.287	STD DEV	2.894
VARIANCE	8.373	KURTOSIS	6.189	SKEWNESS	2.073
MINIMUM	1.000	MAXIMUM	18.000	SUM	402.000
C.V. PCT	73.419	.95 C.I.	3.373	TO	4.510
VALID CASES	102	MISSING CASES	0		

VARIABLE VAR002 LONGEST STAY

MEAN	39.490	STD ERR	3.091	STD DEV	31.214
VARIANCE	974.292	KURTOSIS	8.777	SKEWNESS	2.445
MINIMUM	3.000	MAXIMUM	203.000	SUM	4028.000
C.V. PCT	79.042	.95 C.I.	33.359	TO	45.621
VALID CASES	102	MISSING CASES	0		

VARIABLE VAR003 TOTAL BED DAYS

MEAN	66.863	STD ERR	4.926	STD DEV	49.751
VARIANCE	2475.149	KURTOSIS	10.358	SKEWNESS	2.409
MINIMUM	3.000	MAXIMUM	353.000	SUM	6820.000
C.V. PCT	74.407	.95 C.I.	57.091	TO	76.635
VALID CASES	102	MISSING CASES	0		

VARIABLE VAR004 AVERAGE DAYS PER ADM

MEAN	22.532	STD ERR	2.206	STD DEV	22.275
VARIANCE	496.174	KURTOSIS	12.071	SKEWNESS	3.111
MINIMUM	2.400	MAXIMUM	144.000	SUM	2298.300
C.V. PCT	98.858	.95 C.I.	18.157	TO	26.908

VARIABLE VAR005 LAST ADMISSION

MEAN	20.735	STD ERR	2.353	STD DEV	23.761
VARIANCE	564.593	KURTOSIS	7.483	SKEWNESS	2.334
MINIMUM	0	MAXIMUM	144.000	SUM	2115.000
C.V. PCT	114.593	.95 C.I.	16.068	TO	25.402

VALID CASES 102 MISSING CASES 0

1

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

5 Z SCORES WERE WRITTEN ON FILE BCDOUT FOR 102 UNWEIGHTED CASES.
1 RECORDS OUTPUT PER CASE.

FORMAT IS (F6.0,F2.0,A4,F4.2,8F8.5). TO INPUT Z-SCORES ONLY, WITHOUT SEQUENCING INFO, USE (16X,8F8.5).

MISSING Z-SCORES ARE OUTPUT AS 999.0. NON-MISSING BUT EXTREME Z-SCORES ARE TRUNCATED TO +99.0 OR -99.0.

VARIABLE	OUTPUT RECORD NNUMBER PER CASE	RECORD COLUMNS	UNWEIGHTED NUMBER OF MISSING CASES
SEQNUM	1	1- 6	
RECORD N	1	7- 8	
SUBFILE	1	9-12	
CASWGT	1	13-16	
VAR001	1	17-24	0
VAR002	1	25-32	0
VAR003	1	33-40	0
VAR004	1	41-48	0
VAR005	1	49-56	0

1

CPU TIME REQUIRED.. .126 SECONDS

```
REGRESSION      VARIABLES = VAR001 TO VAR005/
                REGRESSION = VAR001 WITH VAR002(3)/
                REGRESSION = VAR001 WITH VAR003(3)/
                REGRESSION = VAR001 WITH VAR004(3)/
                REGRESSION = VAR001 WITH VAR005(3)/
                REGRESSION = VAR002 WITH VAR003(3)/
                REGRESSION = VAR002 WITH VAR004(3)/
                REGRESSION = VAR002 WITH VAR005(3)/
                REGRESSION = VAR003 WITH VAR004(3)/
                REGRESSION = VAR003 WITH VAR005(3)/
                REGRESSION = VAR004 WITH VAR005(3)/
STATISTICS      ALL
```

00051300 CM NEEDED FOR REGRESSION

IGNORE MISSING VALUE INDICATORS
(NO MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED)

1 83/04/25. 14.36.18. PAGE 6

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82
0* M U L T I P L E R E G R E S S I O N *
*

VARIABLE	MEAN	STANDARD DEV	CASES
VAR001	3.9412	2.8936	102
VAR002	39.4902	31.2137	102
VAR003	66.8627	49.7509	102
VAR004	22.5324	22.2750	102
VAR005	20.7353	23.7612	102

CORRELATION COEFFICIENTS.

A VALUE OF 99.00000 IS PRINTED
IF A COEFFICIENT CANNOT BE COMPUTED.

VAR002	-.06710			
VAR003	.31384	.83111		
VAR004	-.34353	.83662	.58402	
VAR005	-.18182	.47411	.39777	.71388
	VAR001	VAR002	VAR003	VAR004

1 83/04/25. 14.36.18. PAGE 7

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82
0* M U L T I P L E R E G R E S S I O N *
*
DEPENDENT VARIABLE.. VAR001 ADMISSIONS

MEAN RESPONSE 3.94118 STD. DEV. 2.89357

VARIABLE(S) ENTERED ON STEP NUMBER 1.. VAR002 LONGEST STAY

MULTIPLE R	.06710	ANALYSIS OF VARIANCE	DF	SUM OF SQUARES	MEAN SQUARE	F SIGNIFICAN
CE						
R SQUARE	.00450	REGRESSION	1.	3.80694	3.80694	.45222 .5
03						
ADJUSTED R SQUARE	0	RESIDUAL	100.	841.84012	8.41840	
STD DEVIATION	2.90145	COEFF OF VARIABILITY	73.6 PCT			

---------- VARIABLES IN THE EQUATION ----------

VARIABLE	B	STD ERROR B	F	BETA

---------- VARIABLES NOT IN THE EQUATION ----------

VARIABLE	PARTIAL	TOLERANCE	F

```
VAR002          -.62198894E-02    .92493148E-02    .45221629        -.0670955
                                                          .503          -.06232
(CONSTANT)       4.1868011        .46470012       81.174400
                                                          .000

ALL VARIABLES ARE IN THE EQUATION.


COEFFICIENTS AND CONFIDENCE INTERVALS.

VARIABLE            B          STD ERROR B          T            95.0 PCT CONFIDENCE INTERVAL

VAR002          -.62198894E-02   .92493148E-02  -.67247029     -.24570267E-01,  .12130488E-01
CONSTANT         4.1868011       .46470012      9.0096837       3.2648493     ,  5.1087529

VARIANCE/COVARIANCE MATRIX OF THE UNNORMALIZED REGRESSION COEFFICIENTS.

VAR002           .00009

                VAR002

1                                                                    83/04/25.    14.36.18.     PAGE    8

 FILE   HOSPICE  (CREATION DATE =  83/04/25.)   DATA 82
 0* * * * * * * * * * * * * * * * * * * * * * * * M U L T I P L E   R E G R E S S I O N * * * * * * * * * * * * * * * * * * * * * * *
*
 ODEPENDENT VARIABLE..    VAR001     ADMISSIONS


                                                S U M M A R Y   T A B L E

  STEP       VARIABLE              F TO       SIGNIFICANCE  MULTIPLE R  R SQUARE  R SQUARE  SIMPLE R        OVERALL F   SIGNIFICANC
E
        ENTERED   REMOVED      ENTER OR REMOVE                                              CHANGE
    1   VAR002                    .45222         .503         .06710     .00450    .00450   -.06710            .45222        .503
1
                                                                                  83/04/25.    14.36.18.     PAGE    9

 FILE   HOSPICE  (CREATION DATE =  83/04/25.)   DATA 82
 0* * * * * * * * * * * * * * * * * * * * * * * * M U L T I P L E   R E G R E S S I O N * * * * * * * * * * * * * * * * * * * * * * *
*
 ODEPENDENT VARIABLE..    VAR001     ADMISSIONS

  MEAN RESPONSE        3.94118      STD. DEV.       2.89357

  VARIABLE(S) ENTERED ON STEP NUMBER   1..   VAR003     TOTAL BED DAYS

  MULTIPLE R           .31384       ANALYSIS OF VARIANCE    DF      SUM OF SQUARES       MEAN SQUARE          F     SIGNIFICAN
CE
  R SQUARE             .09850       REGRESSION               1.          83.29362          83.29362        10.92585        .0
01
  ADJUSTED R SQUARE    .08948       RESIDUAL               100.         762.35344           7.62353
  STD DEVIATION       2.76107       COEFF OF VARIABILITY  70.1 PCT


 ---------------------- VARIABLES IN THE EQUATION ----------------------          ---------- VARIABLES NOT IN THE EQUATION ---------
--
```

VARIABLE	B	STD ERROR B	F SIGNIFICANCE	BETA ELASTICITY	VARIABLE	PARTIAL	TOLERANCE	F SIGNIFICANCE
VAR003	.18253430E-01	.55222593E-02	10.925854 .001	.3138422				
(CONSTANT)	2.7207020	.45942774	35.069335 .000	.30967				

ALL VARIABLES ARE IN THE EQUATION.

COEFFICIENTS AND CONFIDENCE INTERVALS.

VARIABLE	B	STD ERROR B	T	95.0 PCT CONFIDENCE INTERVAL
VAR003	.18253430E-01	.55222593E-02	3.3054280	.72974251E-02, .29209436E-01
CONSTANT	2.7207020	.45942774	5.9219367	1.8092105 , 3.6321936

VARIANCE/COVARIANCE MATRIX OF THE UNNORMALIZED REGRESSION COEFFICIENTS.

VAR003 .00003

VAR003

1

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82 83/04/25. 14.36.18. PAGE 10

0* M U L T I P L E R E G R E S S I O N *

*

ODEPENDENT VARIABLE.. VAR001 ADMISSIONS

S U M M A R Y T A B L E

STEP	VARIABLE ENTERED	VARIABLE REMOVED	F TO ENTER OR REMOVE	SIGNIFICANCE	MULTIPLE R	R SQUARE	R SQUARE CHANGE	SIMPLE R	OVERALL F	SIGNIFICANC
1	1 VAR003		10.92585	.001	.31384	.09850	.09850	.31384	10.92585	.001

E

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82 83/04/25. 14.36.18. PAGE 11

0* M U L T I P L E R E G R E S S I O N *

*

ODEPENDENT VARIABLE.. VAR001 ADMISSIONS

MEAN RESPONSE 3.94118 STD. DEV. 2.89357

VARIABLE(S) ENTERED ON STEP NUMBER 1.. VAR004 AVERAGE DAYS PER ADM

		ANALYSIS OF VARIANCE	DF	SUM OF SQUARES	MEAN SQUARE	F	SIGNIFICAN
MULTIPLE R	.34353						
CE							
R SQUARE	.11801	REGRESSION	1.	99.79450	99.79450	13.37992	.0
00							
ADJUSTED R SQUARE	.10919	RESIDUAL	100.	745.85256	7.45853		
STD DEVIATION	2.73103	COEFF OF VARIABILITY	69.3 PCT				

---------- VARIABLES IN THE EQUATION ----------

VARIABLE	B	STD ERROR B	F SIGNIFICANCE	BETA ELASTICITY
VAR004	-.44624710E-01	.12199684E-01	13.379923 .000	-.3435253 -.25513
(CONSTANT)	4.9466762	.38559822	164.57237 0	

---------- VARIABLES NOT IN THE EQUATION ----------

VARIABLE	PARTIAL	TOLERANCE	F SIGNIFICANCE

ALL VARIABLES ARE IN THE EQUATION.

COEFFICIENTS AND CONFIDENCE INTERVALS.

VARIABLE	B	STD ERROR B	T	95.0 PCT CONFIDENCE INTERVAL
VAR004	-.44624710E-01	.12199684E-01	-3.6578578	-.68828536E-01, -.20420883E-01
CONSTANT	4.9466762	.38559822	12.828576	4.1816603 , 5.7116921

VARIANCE/COVARIANCE MATRIX OF THE UNNORMALIZED REGRESSION COEFFICIENTS.

VAR004	.00015

VAR004

1

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

0* M U L T I P L E R E G R E S S I O N *

*

DEPENDENT VARIABLE.. VAR001 ADMISSIONS

S U M M A R Y T A B L E

STEP	VARIABLE ENTERED	VARIABLE REMOVED	F TO ENTER OR REMOVE	SIGNIFICANCE	MULTIPLE R	R SQUARE	R SQUARE CHANGE	SIMPLE R	OVERALL F	SIGNIFICANCE
1	VAR004		13.37992	.000	.34353	.11801	.11801	-.34353	13.37992	.000

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

0* M U L T I P L E R E G R E S S I O N *

*

DEPENDENT VARIABLE.. VAR001 ADMISSIONS

MEAN RESPONSE 3.94118 STD. DEV. 2.89357

VARIABLE(S) ENTERED ON STEP NUMBER 1.. VAR005 LAST ADMISSION

MULTIPLE R	.18182	ANALYSIS OF VARIANCE	DF	SUM OF SQUARES	MEAN SQUARE	F	SIGNIFICANCE
R SQUARE	.03306	REGRESSION	1.	27.95548	27.95548	3.41883	.067
ADJUSTED R SQUARE	.02339	RESIDUAL	100.	817.69158	8.17692		

```
---------- VARIABLES IN THE EQUATION ----------                    ---------- VARIABLES NOT IN THE EQUATION ---------
--

 VARIABLE          B          STD ERROR B        F                  BETA                VARIABLE      PARTIAL     TOLERANCE       F
                                                 SIGNIFICANCE       ELASTICITY                                                   SIGNIFICANCE

 VAR005      -.22141405E-01   .11974751E-01   3.4188291            -.1818188
                                                  .067                -.11649
 (CONSTANT)   4.4002850       .37658826       136.52999
                                                  .000

 ALL VARIABLES ARE IN THE EQUATION.


 COEFFICIENTS AND CONFIDENCE INTERVALS.

 VARIABLE          B          STD ERROR B          T          95.0 PCT CONFIDENCE INTERVAL

 VAR005      -.22141405E-01   .11974751E-01 -1.8490076        -.45898970E-01,  .16161595E-02
 CONSTANT     4.4002850       .37658826      11.684605         3.6531446    ,  5.1474254

 VARIANCE/COVARIANCE MATRIX OF THE UNNORMALIZED REGRESSION COEFFICIENTS.

 VAR005        .00014

               VAR005

1                                                                    83/04/25.    14.36.18.     PAGE   14

 FILE   HOSPICE  (CREATION DATE =  83/04/25.)   DATA 82
0* * * * * * * * * * * * * * * * * * * * * * M U L T I P L E   R E G R E S S I O N * * * * * * * * * * * * * * * * * * * * * * *
*
 ODEPENDENT VARIABLE..    VAR001     ADMISSIONS

                                                S U M M A R Y   T A B L E

 STEP       VARIABLE              F TO       SIGNIFICANCE  MULTIPLE R  R SQUARE  R SQUARE  SIMPLE R        OVERALL F   SIGNIFICANC
E
       ENTERED   REMOVED      ENTER OR REMOVE                                      CHANGE

    1   VAR005                  3.41883         .067        .18182    .03306    .03306   -.18182          3.41883        .067
1                                                                    83/04/25.    14.36.18.     PAGE   15

 FILE   HOSPICE  (CREATION DATE =  83/04/25.)   DATA 82
0* * * * * * * * * * * * * * * * * * * * * * M U L T I P L E   R E G R E S S I O N * * * * * * * * * * * * * * * * * * * * * * *
*
 ODEPENDENT VARIABLE..    VAR002     LONGEST STAY

 MEAN RESPONSE      39.49020      STD. DEV.      31.21365

 VARIABLE(S) ENTERED ON STEP NUMBER   1..   VAR003     TOTAL BED DAYS


 MULTIPLE R          .83111        ANALYSIS OF VARIANCE    DF      SUM OF SQUARES        MEAN SQUARE            F      SIGNIFICAN
CE
```

0
ADJUSTED R SQUARE .68766 RESIDUAL 100. 30431.23167 304.31232
STD DEVIATION 17.44455 COEFF OF VARIABILITY 44.2 PCT

---------- VARIABLES IN THE EQUATION ----------

VARIABLE	B	STD ERROR B	F SIGNIFICANCE	BETA ELASTICITY
VAR003	.52144014	.34889792E-01	223.36348 0	.8311140 .88288
(CONSTANT)	4.6252766	2.9026776	2.5390884 .114	

---------- VARIABLES NOT IN THE EQUATION ----------

VARIABLE	PARTIAL	TOLERANCE	F SIGNIFICANCE

ALL VARIABLES ARE IN THE EQUATION.

COEFFICIENTS AND CONFIDENCE INTERVALS.

VARIABLE	B	STD ERROR B	T	95.0 PCT CONFIDENCE INTERVAL
VAR003	.52144014	.34889792E-01	14.945350	.45221979 , .59066050
CONSTANT	4.6252766	2.9026776	1.5934517	-1.1335531 , 10.384106

VARIANCE/COVARIANCE MATRIX OF THE UNNORMALIZED REGRESSION COEFFICIENTS.

VAR003 .00122

VAR003

1 83/04/25. 14.36.18. PAGE 16

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82
0* M U L T I P L E R E G R E S S I O N *
*
ODEPENDENT VARIABLE.. VAR002 LONGEST STAY

S U M M A R Y T A B L E

STEP	VARIABLE ENTERED	VARIABLE REMOVED	F TO ENTER OR REMOVE	SIGNIFICANCE	MULTIPLE R	R SQUARE	R SQUARE CHANGE	SIMPLE R	OVERALL F	SIGNIFICANCE
1	VAR003		223.36348	0	.83111	.69075	.69075	.83111	223.36348	0

1 83/04/25. 14.36.18. PAGE 17

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82
0* M U L T I P L E R E G R E S S I O N *
*
ODEPENDENT VARIABLE.. VAR002 LONGEST STAY

MEAN RESPONSE 39.49020 STD. DEV. 31.21365

VARIABLE(S) ENTERED ON STEP NUMBER 1.. VAR004 AVERAGE DAYS PER ADM

MULTIPLE R .83662
R SQUARE .69993
ADJUSTED R SQUARE .69693
STD DEVIATION 17.18367

ANALYSIS OF VARIANCE	DF	SUM OF SQUARES	MEAN SQUARE	F	SIGNIFICANCE
REGRESSION	1.	68875.63109	68875.63109	233.25643	0
RESIDUAL	100.	29527.85910	295.27859		
COEFF OF VARIABILITY	43.5 PCT				

VARIABLES IN THE EQUATION

VARIABLE	B	STD ERROR B	F SIGNIFICANCE	BETA ELASTICITY
VAR004	1.1723435	.76760550E-01	233.25643 0	.8366187 .66892
(CONSTANT)	13.074538	2.4261883	29.040472 .000	

VARIABLES NOT IN THE EQUATION

VARIABLE	PARTIAL	TOLERANCE	F SIGNIFICANCE

ALL VARIABLES ARE IN THE EQUATION.

COEFFICIENTS AND CONFIDENCE INTERVALS.

VARIABLE	B	STD ERROR B	T	95.0 PCT CONFIDENCE INTERVAL
VAR004	1.1723435	.76760550E-01	15.272735	1.0200528 , 1.3246343
CONSTANT	13.074538	2.4261883	5.3889212	8.2610491 , 17.888026

VARIANCE/COVARIANCE MATRIX OF THE UNNORMALIZED REGRESSION COEFFICIENTS.

VAR004 .00589

VAR004

1

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82
0* M U L T I P L E R E G R E S S I O N *
*
DEPENDENT VARIABLE.. VAR002 LONGEST STAY

S U M M A R Y T A B L E

STEP	VARIABLE ENTERED	VARIABLE REMOVED	F TO ENTER OR REMOVE	SIGNIFICANCE	MULTIPLE R	R SQUARE	R SQUARE CHANGE	SIMPLE R	OVERALL F	SIGNIFICANCE
1	VAR004		233.25643	0	.83662	.69993	.69993	.83662	233.25643	0

1

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82
0* M U L T I P L E R E G R E S S I O N *
*
DEPENDENT VARIABLE.. VAR002 LONGEST STAY

MEAN RESPONSE 39.49020 STD. DEV. 31.21365

VARIABLE(S) ENTERED ON STEP NUMBER 1.. VAR005 LAST ADMISSION

MULTIPLE R	.47411	ANALYSIS OF VARIANCE	DF	SUM OF SQUARES	MEAN SQUARE	F SIGNIFICAN
CE						
R SQUARE	.22478	REGRESSION	1.	22119.37414	22119.37414	28.99604 .0
00						
ADJUSTED R SQUARE	.21703	RESIDUAL	100.	76284.11606	762.84116	
STD DEVIATION	27.61958	COEFF OF VARIABILITY	69.9 PCT			

---------- VARIABLES IN THE EQUATION ----------

VARIABLE	B	STD ERROR B	F SIGNIFICANCE	BETA ELASTICITY
VAR005	.62281367	.11566149	28.996042 .000	.4741122 .32702
(CONSTANT)	26.575971	3.6373834	53.382651 .000	

---------- VARIABLES NOT IN THE EQUATION ----------

VARIABLE	PARTIAL	TOLERANCE	F SIGNIFICANCE

ALL VARIABLES ARE IN THE EQUATION.

COEFFICIENTS AND CONFIDENCE INTERVALS.

VARIABLE	B	STD ERROR B	T	95.0 PCT CONFIDENCE INTERVAL
VAR005	.62281367	.11566149	5.3847973	.39334457 , .85228278
CONSTANT	26.575971	3.6373834	7.3063432	19.359506 , 33.792436

VARIANCE/COVARIANCE MATRIX OF THE UNNORMALIZED REGRESSION COEFFICIENTS.

VAR005	.01338

VAR005

1

ODEPENDENT VARIABLE.. VAR002 LONGEST STAY

S U M M A R Y T A B L E

STEP	VARIABLE ENTERED	VARIABLE REMOVED	F TO ENTER OR REMOVE	SIGNIFICANCE	MULTIPLE R	R SQUARE	R SQUARE CHANGE	SIMPLE R	OVERALL F	SIGNIFICANCE
1	VAR005		28.99604	.000	.47411	.22478	.22478	.47411	28.99604	.000

1

MEAN RESPONSE 66.86275 STD. DEV. 49.75087

VARIABLE(S) ENTERED ON STEP NUMBER 1.. VAR004 AVERAGE DAYS PER ADM

MULTIPLE R	.58402	ANALYSIS OF VARIANCE	DF	SUM OF SQUARES	MEAN SQUARE	F SIGNIFICANCE
R SQUARE	.34108	REGRESSION	1.	85266.92672	85266.92672	51.76378 .000
ADJUSTED R SQUARE	.33449	RESIDUAL	100.	164723.15171	1647.23152	
STD DEVIATION	40.58610	COEFF OF VARIABILITY	60.7 PCT			

---------- VARIABLES IN THE EQUATION ----------

VARIABLE	B	STD ERROR B	F SIGNIFICANCE	BETA ELASTICITY
VAR004	1.3044048	.18130067	51.763778 .000	.5840216 .43958
(CONSTANT)	37.471435	5.7304120	42.759138 .000	

---------- VARIABLES NOT IN THE EQUATION ----------

VARIABLE	PARTIAL	TOLERANCE	F SIGNIFICANCE

ALL VARIABLES ARE IN THE EQUATION.

COEFFICIENTS AND CONFIDENCE INTERVALS.

VARIABLE	B	STD ERROR B	T	95.0 PCT CONFIDENCE INTERVAL
VAR004	1.3044048	.18130067	7.1947049	.94470947 , 1.6641002
CONSTANT	37.471435	5.7304120	6.5390472	26.102460 , 48.840409

VARIANCE/COVARIANCE MATRIX OF THE UNNORMALIZED REGRESSION COEFFICIENTS.

VAR004 .03287

VAR004

1 83/04/25. 14.36.18. PAGE 22

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

0* M U L T I P L E R E G R E S S I O N *

*

ODEPENDENT VARIABLE.. VAR003 TOTAL BED DAYS

%

S U M M A R Y T A B L E

STEP	VARIABLE ENTERED	VARIABLE REMOVED	F TO ENTER OR REMOVE	SIGNIFICANCE	MULTIPLE R	R SQUARE	R SQUARE CHANGE	SIMPLE R	OVERALL F	SIGNIFICANCE
1	VAR004		51.76378	.000	.58402	.34108	.34108	.58402	51.76378	.000

1 83/04/25. 14.36.18. PAGE 23

0* M U L T I P L E R E G R E S S I O N *

*

DEPENDENT VARIABLE.. VAR003 TOTAL BED DAYS

MEAN RESPONSE 66.86275 STD. DEV. 49.75087

VARIABLE(S) ENTERED ON STEP NUMBER 1.. VAR005 LAST ADMISSION

MULTIPLE R	.39777	ANALYSIS OF VARIANCE	DF	SUM OF SQUARES	MEAN SQUARE	F SIGNIFICANCE
R SQUARE	.15822	REGRESSION	1.	39553.93900	39553.93900	18.79617 .000
ADJUSTED R SQUARE	.14980	RESIDUAL	100.	210436.13944	2104.36139	
STD DEVIATION	45.87332	COEFF OF VARIABILITY	68.6 PCT			

VARIABLES IN THE EQUATION

VARIABLE	B	STD ERROR B	F SIGNIFICANCE	BETA ELASTICITY
VAR005	.83284962	.19210200	18.796172 .000	.3977713 .2587
(CONSTANT)	49.593363	6.0413248	67.388030 .000	

VARIABLES NOT IN THE EQUATION

VARIABLE	PARTIAL	TOLERANCE	F SIGNIFICANCE

ALL VARIABLES ARE IN THE EQUATION.

COEFFICIENTS AND CONFIDENCE INTERVALS.

VARIABLE	B	STD ERROR B	T	95.0 PCT CONFIDENCE INTERVAL
VAR005	.83284962	.19210200	4.3354552	.45172472 , 1.2139745
CONSTANT	49.593363	6.0413248	8.2090213	37.607547 , 61.579180

VARIANCE/COVARIANCE MATRIX OF THE UNNORMALIZED REGRESSION COEFFICIENTS.

	VAR005
VAR005	.03690

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

0* M U L T I P L E R E G R E S S I O N *

*

DEPENDENT VARIABLE.. VAR003 TOTAL BED DAYS

S U M M A R Y T A B L E

STEP	VARIABLE ENTERED	VARIABLE REMOVED	F TO ENTER OR REMOVE	SIGNIFICANCE	MULTIPLE R	R SQUARE	R SQUARE CHANGE	SIMPLE R	OVERALL F	SIGNIFICANCE

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

0* M U L T I P L E R E G R E S S I O N *

*

DEPENDENT VARIABLE.. VAR004 AVERAGE DAYS PER ADM

MEAN RESPONSE 22.53235 STD. DEV. 22.27497

VARIABLE(S) ENTERED ON STEP NUMBER 1.. VAR005 LAST ADMISSION

MULTIPLE R	.71388	ANALYSIS OF VARIANCE	DF	SUM OF SQUARES	MEAN SQUARE	F SIGNIFICANCE
R SQUARE	.50963	REGRESSION	1.	25539.47245	25539.47245	103.92820 .000
ADJUSTED R SQUARE	.50473	RESIDUAL	100.	24574.15079	245.74151	
STD DEVIATION	15.67614	COEFF OF VARIABILITY	69.6 PCT			

---------- VARIABLES IN THE EQUATION ----------

VARIABLE	B	STD ERROR B	F SIGNIFICANCE	BETA ELASTICITY
VAR005	.66923351	.65646410E-01	103.92820 .000	.7138847 .61586
(CONSTANT)	8.6555992	2.0644828	17.578091 .000	

---------- VARIABLES NOT IN THE EQUATION ----------

VARIABLE	PARTIAL	TOLERANCE	F SIGNIFICANCE

ALL VARIABLES ARE IN THE EQUATION.

COEFFICIENTS AND CONFIDENCE INTERVALS.

VARIABLE	B	STD ERROR B	t	95.0 PCT CONFIDENCE INTERVAL
VAR005	.66923351	.65646410E-01	10.194518	.53899291 , .79947412
CONSTANT	8.6555992	2.0644828	4.1926234	4.5597240 , 12.751474

VARIANCE/COVARIANCE MATRIX OF THE UNNORMALIZED REGRESSION COEFFICIENTS.

VAR005 .00431

VAR005

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

0* M U L T I P L E R E G R E S S I O N *

*

DEPENDENT VARIABLE.. VAR004 AVERAGE DAYS PER ADM

S U M M A R Y T A B L E

STEP	VARIABLE	F TO	SIGNIFICANCE	MULTIPLE R	R SQUARE	R SQUARE	SIMPLE R	OVERALL F	SIGNIFICANCE

```
          ENTERED   REMOVED      ENTER OR REMOVE                                    CHANGE

     1    VAR005                    103.92820        .000        .71388    .50963    .50963    .71388        103.92820        .000
1                                                                                  83/04/25.     14.36.18.     PAGE   27

 CPU TIME REQUIRED..        .269 SECONDS


                      FINISH

 TOTAL CPU TIME USED..        .496 SECONDS


 RUN COMPLETED

 NUMBER OF CONTROL CARDS READ  27
 NUMBER OF ERRORS DETECTED      0
 S
--EOR--
--EOR--
END OF FILE
??
```

```
--EOR--          HH      HH  IIIIIIIIII  AA      AA      II          II
11
 1

          BOULDER DOC LABORATORIES                                        83/04/25.    14.57.08.     PAGE    1

          S P S S - - STATISTICAL PACKAGE FOR THE SOCIAL SCIENCES

          VERSION 8.3 (NOS) -- MAY 04, 1982

          263700 CM MAXIMUM FIELD LENGTH REQUEST


                    FILE NAME       HOSPICE DATA 82
                    VARIABLE LIST   VAR001 TO VAR006
                    INPUT MEDIUM    DISK
                    N OF CASES      UNKNOWN
                    INPUT FORMAT    FIXED (F2.0,F3.0,F3.0,F5.1,F3.0,F1.0)

                   ACCORDING TO YOUR INPUT FORMAT, VARIABLES ARE TO BE READ AS FOLLOWS

                   VARIABLE  FORMAT  RECORD    COLUMNS

                   VAR001    F 2. 0      1     1-   2
                   VAR002    F 3. 0      1     3-   5
                   VAR003    F 3. 0      1     6-   8
                   VAR004    F 5. 1      1     9-  13
                   VAR005    F 3. 0      1    14-  16
                   VAR006    F 1. 0      1    17-  17

THE INPUT FORMAT PROVIDES FOR   6 VARIABLES.    6 WILL BE READ.
IT PROVIDES FOR  1 RECORDS (*CARDS*) PER CASE.
A MAXIMUM OF    17 *COLUMNS* ARE USED ON A RECORD.

                   VAR LABELS      VAR001  ADMISSIONS          /VAR002  LONGEST STAY        /
                                   VAR003  TOTAL BED DAYS      /VAR004  AVERAGE DAYS PER ADM/
                                   VAR005  LAST ADMISSION      /VAR006  GENDER
                   PRINT FORMATS   VAR001 (0)/VAR002 (0)/VAR003 (0)/VAR004 (1)/VAR005 (0)/
                                   VAR006 (0)
                   READ INPUT      DATA

CPU TIME REQUIRED..        .044 SECONDS


END OF FILE ON FILE FAMDAT
AFTER READING    102 CASES FROM SUBFILE HOSPICE
1
                                                                   83/04/25.    14.57.08.     PAGE    2

CPU TIME REQUIRED..        .051 SECONDS


                   PEARSON CORR    VAR001 TO VAR005 WITH VAR001 TO VAR005
                   STATISTICS      ALL

          00043500 CM NEEDED FOR PEARSON CORR

          OPTION = 1
          IGNORE MISSING VALUE INDICATORS
```

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

VARIABLE	CASES	MEAN	STD DEV
VAR001	102	3.9412	2.8936
VAR002	102	39.4902	31.2137
VAR003	102	66.8627	49.7509
VAR004	102	22.5324	22.2750
VAR005	102	20.7353	23.7612

VARIABLES		CASES	CROSS-PROD DEV	COVARIANCE
VAR001	VAR001	102	845.6471	8.3727
VAR001	VAR003	102	4563.1765	45.1800
VAR001	VAR005	102	-1262.5882	-12.5009
VAR002	VAR002	102	98403.4902	974.2920
VAR002	VAR004	102	58750.3824	581.6870
VAR003	VAR001	102	4563.1765	45.1800
VAR003	VAR003	102	249990.0784	2475.1493
VAR003	VAR005	102	47492.2941	470.2207
VAR004	VAR002	102	58750.3824	581.6870
VAR004	VAR004	102	50113.6232	496.1745
VAR005	VAR001	102	-1262.5882	-12.5009
VAR005	VAR003	102	47492.2941	470.2207
VAR005	VAR005	102	57023.8529	564.5926

VARIABLES		CASES	CROSS-PROD DEV	COVARIANCE
VAR001	VAR002	102	-612.0588	-6.0600
VAR001	VAR004	102	-2236.3059	-22.1416
VAR002	VAR001	102	-612.0588	-6.0600
VAR002	VAR003	102	130354.8627	1290.6422
VAR002	VAR005	102	35515.2353	351.6360
VAR003	VAR002	102	130354.8627	1290.6422
VAR003	VAR004	102	65368.4529	647.2124
VAR004	VAR001	102	-2236.3059	-22.1416
VAR004	VAR003	102	65368.4529	647.2124
VAR004	VAR005	102	38162.2735	377.8443
VAR005	VAR002	102	35515.2353	351.6360
VAR005	VAR004	102	38162.2735	377.8443

- - - - - - - - - - - - PEARSON CORRELATION COEFFICIENTS - - - - - - - - - - -

	VAR001	VAR002	VAR003	VAR004	VAR005
VAR001	1.0000	-.0671	.3138	-.3435	-.1818
	(102)	(102)	(102)	(102)	(102)
	P= .001	P= .251	P= .001	P= .001	P= .034
VAR002	-.0671	1.0000	.8311	.8366	.4741
	(102)	(102)	(102)	(102)	(102)
	P= .251	P= .001	P= .001	P= .001	P= .001
VAR003	.3138	.8311	1.0000	.5840	.3978
	(102)	(102)	(102)	(102)	(102)
	P= .001	P= .001	P= .001	P= .001	P= .001
VAR004	-.3435	.8366	.5840	1.0000	.7139
	(102)	(102)	(102)	(102)	(102)
	P= .001	P= .001	P= .001	P= .001	P= .001

```
              (   102)  (   102)  (   102)  (   102)  (   102)
              P=  .034  P=  .001  P=  .001  P=  .001  P=  .001

   (COEFFICIENT / CASES / SIGNFICANCE)    (99.0000 MEANS UNCOMPUTABLE)



1                                                                  83/04/25.    14.57.08.     PAGE    4

   CPU TIME REQUIRED..        .059 SECONDS

                        FINISH

   TOTAL CPU TIME USED..        .155 SECONDS


   RUN COMPLETED

   NUMBER OF CONTROL CARDS READ  14
   NUMBER OF ERRORS DETECTED      0
  S
--EOR--
--EOR--
END OF FILE
?/
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  HH      HH  IIIIIIIIII  AA      AA      TT          TT
 --EOR--
11
 T
                                                                    83/04/25.    15.32.52.     PAGE    1
          BOULDER DOC LABORATORIES

          S P S S - - STATISTICAL PACKAGE FOR THE SOCIAL SCIENCES

          VERSION 8.3 (NOS) -- MAY 04, 1982

          263700 CM MAXIMUM FIELD LENGTH REQUEST


                    FILE NAME      HOSPICE DATA 82
                    VARIABLE LIST  VAR001 TO VAR006
                    INPUT MEDIUM   DISK
                    N OF CASES     UNKNOWN
                    INPUT FORMAT   FIXED (F2.0,F3.0,F3.0,F5.1,F3.0,F1.0)


                    ACCORDING TO YOUR INPUT FORMAT, VARIABLES ARE TO BE READ AS FOLLOWS

                    VARIABLE  FORMAT  RECORD    COLUMNS

                    VAR001    F 2. 0      1     1-   2
                    VAR002    F 3. 0      1     3-   5
                    VAR003    F 3. 0      1     6-   8
                    VAR004    F 5. 1      1     9-  13
                    VAR005    F 3. 0      1    14-  16
                    VAR006    F 1. 0      1    17-  17

THE INPUT FORMAT PROVIDES FOR   6 VARIABLES.    6 WILL BE READ.
IT PROVIDES FOR  1 RECORDS (*CARDS*) PER CASE.
A MAXIMUM OF    17 *COLUMNS* ARE USED ON A RECORD.

                    VAR LABELS     VAR001  ADMISSIONS          /VAR002  LONGEST STAY        /
                                   VAR003  TOTAL BED DAYS      /VAR004  AVERAGE DAYS PER ADM/
                                   VAR005  LAST ADMISSION      /VAR006  GENDER
                    PRINT FORMATS  VAR001 (0)/VAR002 (0)/VAR003 (0)/VAR004 (1)/VAR005 (0)/
                                   VAR006 (0)

CPU TIME REQUIRED..       .038 SECONDS


                    ANOVA          VAR002 BY VAR001(1,99)/

               00075600 CM NEEDED FOR ANOVA

               OPTION - 1
               IGNORE MISSING VALUE INDICATORS
               (NO MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED)
```

```
                    VAR003     F 3. 0          1      8-   10
                    VAR004     F 5. 1          1      9-   13
                    VAR005     F 3. 0          1     14-   16
                    VAR006     F 1. 0          1     17-   17

THE INPUT FORMAT PROVIDES FOR   6 VARIABLES.     6 WILL BE READ.
IT PROVIDES FOR  1 RECORDS (*CARDS*) PER CASE.
A MAXIMUM OF    17 COLUMNS* ARE USED ON A RECORD.

                    VAR LABELS     VAR001  ADMISSIONS          /VAR002  LONGEST STAY        /
                                   VAR003  TOTAL BED DAYS      /VAR004  AVERAGE DAYS PER ADM/
                                   VAR005  LAST ADMISSION      /VAR006  GENDER
                    PRINT FORMATS  VAR001 (0)/VAR002 (0)/VAR003 (0)/VAR004 (1)/VAR005 (0)/
                                   VAR006 (0)

CPU TIME REQUIRED..        .038 SECONDS


                    ANOVA          VAR002 BY VAR001(1,99)/

            00075600 CM NEEDED FOR ANOVA

            OPTION - 1
            IGNORE MISSING VALUE INDICATORS
            (NO MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED)




END OF FILE ON FILE FAMDAT
AFTER READING    102 CASES FROM SUBFILE HOSPICE
1                                                                    83/04/25.    15.32.52.    PAGE    2

FILE   HOSPICE  (CREATION DATE =  83/04/25.)   DATA 82

* * * * * * * * A N A L Y S I S   O F   V A R I A N C E * * * * * * * *
             VAR002   LONGEST STAY
          BY VAR001   ADMISSIONS
* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *


                                    SUM OF                  MEAN          SIGNIF
SOURCE OF VARIATION                 SQUARES      DF        SQUARE      F    OF F

MAIN EFFECTS                       3931.325      12       327.610    .309    .986
```

EXPLAINED	3931.325	12	327.610	.309	.986
RESIDUAL	94472.165	89	1061.485		
TOTAL	98403.490	101	974.292		

102 CASES WERE PROCESSED.
0 CASES (0 PCT) WERE MISSING.

1 83/04/25. 15.32.52. PAGE 3

CPU TIME REQUIRED.. .086 SECONDS

```
ANOVA          VAR003 BY VAR001(1,99)/

00073600 CM NEEDED FOR ANOVA

OPTION - 1
IGNORE MISSING VALUE INDICATORS
(NO MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED)
```

1 83/04/25. 15.32.52. PAGE 4

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

* * * * * * * * A N A L Y S I S O F V A R I A N C E * * * * * * * *

VAR003 TOTAL BED DAYS
BY VAR001 ADMISSIONS

* *

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIF OF F
MAIN EFFECTS	47556.099	12	3963.008	1.742	.071
VAR001	47556.099	12	3963.008	1.742	.071
EXPLAINED	47556.099	12	3963.008	1.742	.071
RESIDUAL	202433.980	89	2274.539		
TOTAL	249990.078	101	2475.149		

102 CASES WERE PROCESSED.
0 CASES (0 PCT) WERE MISSING.

1 83/04/25. 15.32.52. PAGE 5

CPU TIME REQUIRED.. .036 SECONDS

```
ANOVA          VAR004 BY VAR001(1,99)/

00073600 CM NEEDED FOR ANOVA

OPTION - 1
```

1

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

* * * * * * * * A N A L Y S I S O F V A R I A N C E * * * * * * * *

VAR004 AVERAGE DAYS PER ADM
BY VAR001 ADMISSIONS

* *

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIF OF F
MAIN EFFECTS	9519.088	12	793.257	1.739	.072
VAR001	9519.088	12	793.257	1.739	.072
EXPLAINED	9519.088	12	793.257	1.739	.072
RESIDUAL	40594.536	89	456.118		
TOTAL	50113.623	101	496.174		

102 CASES WERE PROCESSED.
0 CASES (0 PCT) WERE MISSING.

1

CPU TIME REQUIRED.. .038 SECONDS

ANOVA VAR005 BY VAR001(1,99)/

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

* * * * * * * * A N A L Y S I S O F V A R I A N C E * * * * * * * *
VAR005 LAST ADMISSION
BY VAR001 ADMISSIONS
* *

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIF OF F
MAIN EFFECTS	9067.439	12	755.620	1.402	.180
VAR001	9067.439	12	755.620	1.402	.180
EXPLAINED	9067.439	12	755.620	1.402	.180
RESIDUAL	47956.414	89	538.836		
TOTAL	57023.853	101	564.593		

102 CASES WERE PROCESSED.
0 CASES (0 PCT) WERE MISSING.

CPU TIME REQUIRED.. .038 SECONDS

ANOVA VAR003 BY VAR002(1,99)/

00073600 CM NEEDED FOR ANOVA

OPTION - 1
IGNORE MISSING VALUE INDICATORS
(NO MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED)

```
          HH      HH  IIIIIIIIII  AA      AA      TT          TT
--EOR--
11
 T
                                                                                    83/04/25.    15.51.59.     PAGE    1
          BOULDER DOC LABORATORIES

          S P S S - - STATISTICAL PACKAGE FOR THE SOCIAL SCIENCES

          VERSION 8.3 (NOS) -- MAY 04, 1982

          263700 CM MAXIMUM FIELD LENGTH REQUEST


                    FILE NAME      HOSPICE DATA 82
                    VARIABLE LIST  VAR001 TO VAR006
                    INPUT MEDIUM   DISK
                    N OF CASES     UNKNOWN
                    INPUT FORMAT   FIXED (F2.0,F3.0,F3.0,F5.1,F3.0,F1.0)


                    ACCORDING TO YOUR INPUT FORMAT, VARIABLES ARE TO BE READ AS FOLLOWS

                    VARIABLE  FORMAT  RECORD    COLUMNS

                    VAR001    F 2. 0      1     1-   2
                    VAR002    F 3. 0      1     3-   5
                    VAR003    F 3. 0      1     6-   8
                    VAR004    F 5. 1      1     9-  13
                    VAR005    F 3. 0      1    14-  16
                    VAR006    F 1. 0      1    17-  17

  THE INPUT FORMAT PROVIDES FOR   6 VARIABLES.    6 WILL BE READ.
  IT PROVIDES FOR  1 RECORDS (*CARDS*) PER CASE.
  A MAXIMUM OF    17 *COLUMNS* ARE USED ON A RECORD.

                     VAR LABELS     VAR001  ADMISSIONS          /VAR002  LONGEST STAY        /
                                    VAR003  TOTAL BED DAYS      /VAR004  AVERAGE DAYS PER ADM/
                                    VAR005  LAST ADMISSION      /VAR006  GENDER
                     PRINT FORMATS  VAR001 (0)/VAR002 (0)/VAR003 (0)/VAR004 (1)/VAR005 (0)/
                                    VAR006 (0)

  CPU TIME REQUIRED..        .041 SECONDS


                     ANOVA          VAR003 BY VAR002(1,203)/

               00175200 CM NEEDED FOR ANOVA

               OPTION - 1
               IGNORE MISSING VALUE INDICATORS
               (NO MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED)




  END OF FILE ON FILE FAMDAT
  AFTER READING    102 CASES FROM PUBFILE HOSPICE
```

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

* * * * * * * * A N A L Y S I S O F V A R I A N C E * * * * * * * *
VAR003 TOTAL BED DAYS
BY VAR002 LONGEST STAY
* *

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIF OF F
MAIN EFFECTS	225208.545	55	4094.701	7.601	.001
VAR002	225208.545	55	4094.701	7.601	.001
EXPLAINED	225208.545	55	4094.701	7.601	.001
RESIDUAL	24781.533	46	538.729		
TOTAL	249990.078	101	2475.149		

102 CASES WERE PROCESSED.
0 CASES (0 PCT) WERE MISSING.

CPU TIME REQUIRED.. .549 SECONDS

ANOVA VAR004 BY VAR002(1,203)/

00173200 CM NEEDED FOR ANOVA

OPTION - 1
IGNORE MISSING VALUE INDICATORS
(NO MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED)

FILE HOSPICE (CREATION DATE = 83/04/25.) DATA 82

* * * * * * * * A N A L Y S I S O F V A R I A N C E * * * * * * * *
VAR004 AVERAGE DAYS PER ADM
BY VAR002 LONGEST STAY
* *

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIF OF F
MAIN EFFECTS	47695.960	55	867.199	16.500	.001
VAR002	47695.960	55	867.199	16.500	.001
EXPLAINED	47695.960	55	867.199	16.500	.001
RESIDUAL	2417.664	46	52.558		
TOTAL	50113.623	101	496.174		

102 CASES WERE PROCESSED.
0 CASES (0 PCT) WERE MISSING.

1 83/04/25. 15.51.59. PAGE 5

CPU TIME REQUIRED.. .475 SECONDS

ANOVA VAR005 BY VAR002(1,203)/

00173200 CM NEEDED FOR ANOVA

OPTION - 1
IGNORE MISSING VALUE INDICATORS
(NO MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED)

1 83/04/25. 15.51.59. PAGE 6

FILE HOSPICF (CREATION DATE = 83/04/25.) DATA 82

* * * * * * * * A N A L Y S I S O F V A R I A N C E * * * * * * * *
VAR005 LAST ADMISSION
BY VAR002 LONGEST STAY
* *

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIF OF F
MAIN EFFECTS	49938.103	55	907.966	5.894	.001
VAR002	49938.103	55	907.966	5.894	.001
EXPLAINED	49938.103	55	907.966	5.894	.001
RESIDUAL	7085.750	46	154.038		
TOTAL	57023.853	101	564.593		

102 CASES WERE PROCESSED.
0 CASES (0 PCT) WERE MISSING.

1 83/04/25. 15.51.59. PAGE 7

CPU TIME REQUIRED.. .496 SECONDS

ANOVA VAR003 BY VAR004(1,144)/

00122000 CM NEEDED FOR ANOVA

OPTION - 1
IGNORE MISSING VALUE INDICATORS
(NO MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED)

FILE HOSFILE (CREATION DATE = 83/04/25.) DATA 82

* * * * * * * * A N A L Y S I S O F V A R I A N C E * * * * * * * *
VAR005 TOTAL BED DAYS
BY VAR004 AVERAGE DAY - PER ADM
* *

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIF OF F
MAIN EFFECTS	186126.895	40	4653.172	4.445	.001
VAR004	186126.895	40	4653.172	4.445	.001
EXPLAINED	186126.895	40	4653.172	4.445	.001
RESIDUAL	63863.183	61	1046.937		
TOTAL	249990.078	101	2475.149		

101 CASES WERE PROCESSED.
0 CASES (0 PCT) WERE MISSING.

83/04/25. 15.51.59. PAGE 9

END TIME REQUIRED.. .212 SECONDS

ANOVA VAR003 BY VAR005(1,1440)

2001,2999 EM NEEDED FOR ANOVA

OPTION = 1
USE MISSING VALUE INDICATORS
200 MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED

83/04/25. 15.51.59. PAGE 10

FILE HOSFILE (CREATION DATE 83/04/25.) DATA 82

* * * * * * * * A N A L Y S I S O F V A R I A N C E * * * * * * * *
VAR003 TOTAL BED DAYS
BY VAR005 LAST ADMISSION
* *

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIF OF F
MAIN EFFECTS	111954.207	42	2665.576	1.107	.356
VAR005	111954.207	42	2665.576	1.107	.356
EXPLAINED	111954.207	42	2665.576	1.107	.356
RESIDUAL	137212.033	57	2407.229		
TOTAL	249166.240	99	2516.831		

102 CASES WERE PROCESSED.
2 CASES (2.0 PCT) WERE MISSING.

83/04/25. 15.51.59. PAGE 11

CPU TIME REQUIRED.. .240 SECONDS

ANOVA VAR005 BY VAR004(1,114)/
READ INPUT DATA

00122000 CM NEEDED FOR ANOVA

OPTION 1
IGNORE MISSING VALUE INDICATORS
(NO MISSING VALUES DEFINED...OPTION 1 MAY HAVE BEEN FORCED)

83/04/25. 15.51.59. PAGE 12

FILE HOSPFILE (CREATION DATE = 83/04/25.) DATA BC

* * * * * * * * A N A L Y S I S O F V A R I A N C E * * * * * * * *
VAR005 LAST ADMISSION
BY VAR004 AVERAGE DAYS PER ADM
* *

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIF OF F
MAIN EFFECTS	45652.436	40	1141.311	6.122	.001
VAR004	45652.436	40	1141.311	6.122	.001
EXPLAINED	45652.436	40	1141.311	6.122	.001
RESIDUAL	11371.417	61	186.417		
TOTAL	57023.853	101	564.593		

102 CASES WERE PROCESSED.
0 CASES (0 PCT) WERE MISSING.

83/04/25. 15.51.59. PAGE 13

CPU TIME REQUIRED.. .210 SECONDS

FINISH

TOTAL CPU TIME USED.. 2.230 SECONDS

RUN COMPLETED

NUMBER OF CONTROL CARDS READ 18
NUMBER OF ERRORS DETECTED 0

EOR

APPENDIX 3

Appendix 3

Uniform Chart of Accounts (UCA) Data FY 82
Source: Resources Management Division, FAMC

	ONCOLOGY	PULMONARY	MICU
Occupied Bed Days (OBD)	4621	4747	2005
Direct Cost/OBD	14.61	10.33	363.69
Purified/OBD*	98.87	102.42	30.19
TOTAL: Direct & Purified	113.48	112.75	393.88
Indirect/OBD**	16.75	21.22	113.44
Ancillary Cost/OBD	46.13	66.25	386.34
Total Expense/OBD	176.36	200.22	893.66

*Purified Expenses - Shared costs - oncology and pulmonary disease located on wards. Health Services Command computer attributes shared ward costs to oncology and pulmonary based on OBDs. These costs are not broken down to direct or indirect. It is assumed by FAMC UCA personnel that most of the expenses would fall into the direct category.

**Indirect Expenses - Depreciation, administration, communication, training, fire and police protection, automated data processing, plant management, utilities, building maintenance, transportation, laundry, etc.

APPENDIX 4

Appendix 4

Cost Comparisons for Care of Three Individual Terminal Patients (Selected to Demonstrate Range of Costs)

Case #1. D.P., a 62 year old retired enlisted man who died of prostatic carcinoma, December 1982. He was originally hospitalized in January 1981, was admitted four times for a total of 42 days, eight of which were in intensive care.

Costs/Inpatient Care

34 days oncology	5643.52
8 days MICU	7149.28
TOTAL	$12,792.80

Costs If In Hospice (Estimated)

Patient classed as terminal after initial three day hospital stay.

Costs involved:	
3 days initial hospital stay	529.08
24 hours clinic visits (every second week)	479.28
20 hours clinic visits (weekly)	399.40
24 hours home nursing care visits	386.86
4 hours oncology pharmacist	64.48
4 hours clinical dietitian	64.48
40 hours clergyman/social worker	714.76
6 days last admission	1058.16
Total Cost	$3,696.50

*Clinic visits could include ancillary specialists.

Home care supplies would be estimated at $10.00 per visit or $240.00 for a total expense of $3,934.50.

Case #2. R.O., an 11 year old dependent son of an active duty Airman died of acute myelogenous lukemia, July 1982. He was originally diagnosed in July 1981 and was admitted 18 times for a total of 65 days. Most of his admissions were two to four days for leukocyte pharesis and similar treatments. R.O. died at home.

Appendix 4 (Continued)

Costs If In Hospice (Estimated)

36 days oncology (leukocyte pharesis is not painful and prolongs life)	6348.96
12 hours clinic visits (every second week)	239.64
10 hours clinic visits (every week)	199.70
16 hours home nursing care visits	257.91
4 hours clinical dietitian	64.48
40 hours clergyman/social worker	714.76
12 hours physical therapy	193.42
Total Cost	$8,018.87

Case #3. A.B., a 60 year old dependent of a deceased retired soldier died of pancreatic carcinoma, April 1982. She had been admitted twice for a total of eight days. She had been diagnosed December 1981.

Costs/Inpatient:

8 days oncology	1410.88

Costs If In Hospice (Estimated)

14 hours clinic visits	279.58
18 hours home nursing care visits	290.15
24 hours clergyman/social worker	428.86
3 days last admission	529.08
Total Costs	$1,527.67

In this case the hospice care would be more expensive (by $116.79). This would hold true for most cases where hospitalization could be avoided under the current system. This is, however, a rare case. Most cases would reflect the savings shown in case #1, case #2 or the example given in the test of the paper for the "typical" patient.

APPENDIX 5

HOSPICE PROJECT
SELF ASSESSMENT AND SURVEY GUIDE

PATIENT/FAMILY AS THE UNIT OF CARE

Goal I: The patient and the patient's family is the unit of care.

Recommended Completion by: The hospice program director.

Completed by and Title: _____

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
1.1.1	The hospice program has a written admission criteria that refers to the following:		
	A. The patient/family's desire and need for hospice services;	1 2 3 4 5 6	
	B. The eligibility of patients who do not have a designated caregiver;	1 2 3 4 5 6	
	C. Any factors with regard to diagnosis, prognosis, or receipt of active treatment that may effect program eligibility.	1 2 3 4 5 6	
1.1.2	There are consent for care forms signed by the patient, and the family or primary caregiver, if applicable.	1 2 3 4 5 6	
1.1.3	The care plan reflects a comprehensive assessment of patient/family needs.	1 2 3 4 5 6	
1.1.4	There is documentation of the participation of the patient and the family or primary caregivers as able, in the development of the care plan.	1 2 3 4 5 6	
1.1.5	The care plan includes specific goals goals for involving the family or primary caregiver.	1 2 3 4 5 6	

DOCUMENTATION Requested For Survey

- Statement of admission criteria.
- Medical records.

Goal II: The hospice program services and care reflect acknowledgement that each patient/family has basic rights, individual beliefs, and/or value system and life philosphy.

Recommended Completion by: The Hospice Program Director.

Completed by and Title: _____

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
1.2.1	The hospice program has a statement of patient/family rights.	1 2 3 4 5 6	
1.2.2	The statement is written in a language understandable to the patients/families served.	1 2 3 4 5 6	
	A. Please indicate the percentage of patient/familes cared for whose primary language is not English.		_____
1.2.3	The statement is available to patients/families.	1 2 3 4 5 6	
1.2.4	The rights include the following:		
	A. A statement assuring the protection of and support of the human and legal rights of each patient/family;	1 2 3 4 5 6	
	B. There is impartial access to treatment regardless of the patient's and family's race, religion, sex, ethnicity, age, or handicap;	1 2 3 4 5 6	
	C. Recognition of each patient's autonomy and personal dignity, and respect for each patient/family in the provision for care and treatment;	1 2 3 4 5 6	
	D. The assurance of individualized treatment for each patient/family which includes:		
	a. The provision of adequate and humane services, regardless of the source of financial support;	1 2 3 4 5 6	
	b. The provision of an individual care plan;	1 2 3 4 5 6	
	c. Periodic review of the care plan as designated by the hospice program;	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
1.2.4.	d. The active participation of all patients who are able to do so, and the responsible parent, relative or guardian of minors or legally incompetent patients in planning for care.	1 2 3 4 5 6	
	e. The provision of an adequate number of competent, qualified, and experienced professional staff to supervise and implement the treatment plan in accordance to the number previously determined by the hospice program director;	1 2 3 4 5 6	

DOCUMENTATION Requested for Survey

- Patient/Family rights statement.
- Bilingual or statements in a language other than English if applicable.

Goal III: In accordance with hospice program admission criteria, program personnel seek to identify, teach, coordinate, and supervise persons (other than interdisciplinary team members) to give care to patients who do not have a family or other primary caregiver.

Recommended completion by: The Hospice Program Director.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
1.3.1	The hospice program accepts patients without a primary caregiver.	___ Yes ___ No	

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
1.3.2 If the hospice program accepts patients without a primary caregiver. There is written policy and procedure that includes but is not limited to the following:		
A. The responsibility and the efforts the program will take to identify primary caregivers for the patient;	1 2 3 4 5 6	
B. Who will be an acceptable primary caregiver;	1 2 3 4 5 6	
C. What instruction this individual will receive from the program;	1 2 3 4 5 6	
D. The program's responsibility to the substitute caregiver;	1 2 3 4 5 6	
E. Under what circumstances the patient will no longer be eligible to receive program services;	1 2 3 4 5 6	
F. The extent of the responsibility of team members.	1 2 3 4 5 6	

DOCUMENTATION Requested for Survey

- If applicable, policy and procedure regarding care of patients without primary caregivers.

HOSPICE PROJECT
SELF ASSESSMENT AND SURVEY GUIDE

INTERDISCIPLINARY TEAM SERVICES

Goal I: An interdisciplinary team consisting of qualified personnel, provides home care and inpatient hospice services. The team services include at least the following:

Bereavement Services
Nursing Services
Physician Services
Psychosocial Support Services
Spiritual Services
Volunteer Services,

And other services deemed necessary for patient/family care. These services are coordinated to assure the ongoing assessment of the patient's and the family's needs and implementation of the patient/family care plan.

Recommended completion by: The hospice program director or coordinator.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
2.1.1 The interdisciplinary services include the following:		
A. Bereavement services;	1 2 3 4 5 6	
B. Nursing services;	1 2 3 4 5 6	
C. Physician services;	1 2 3 4 5 6	
D. Psychosocial support services;	1 2 3 4 5 6	
E. Spiritual services;	1 2 3 4 5 6	
F. Volunteer services;	1 2 3 4 5 6	
G. And other services deemed necessary in the patient/family care plan.	1 2 3 4 5 6	
2.1.2 There are written policies and procedures		
A. Stating what services are provided;	1 2 3 4 5 6	
B. Who is responsible for initial assessment and the preparation of the care plan;	1 2 3 4 5 6	
C. And ongoing assessment and implementation of the patient's and the family's physical and psychosocial needs, and revision of the care plan.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

2.1.3 Interdisciplinary team members conduct regularly scheduled team case conferences which are documented in the medical record. 1 2 3 4 5 6

A. Please state how often each patient/family care plan is reviewed: _____

2.1.4 The interdisciplinary team services are coordinated by a qualified health care professional designated by the hospice program director. 1 2 3 4 5 6

A. Please state the name and title of the coordinator: _____

B. Briefly state his/her education and training: _____

_____

2.1.5 The responsibilities involved in team service coordination are stated in writing and include, but are not limited to:

A. Coordination of interdisciplinary team reports at conferences in the absence of team members; 1 2 3 4 5 6

B. Planning and implementation of regular and interim patient/family conferences. 1 2 3 4 5 6

DOCUMENTATION Requested During Survey

- Written description of interdisciplinary team services provided.
- Program policy and procedure regarding provision of services, and delivery of services delineating responsibility for initial and ongoing assessment of patient/family needs and revision of the care plan.
- Job description and qualifications of the coordinator.

Goal II: The interdisciplinary team has access to emotional support, and to inservice and continuing education on a regular basis.

Recommended Completion by: The hospice program director or designee.

Completed by and title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.2.1	The hospice program director or designee is responsible for developing and maintaining a staff support program which includes but is not limited to the following:		
	A. Direction by a qualified individual who has an understanding of group dynamics, and of hospice care and the stress associated with care of the patient/family.	1 2 3 4 5 6	
	B. Please state the name and title of the person directing the staff support program: _____		
	C. Briefly state the training and experience of this individual: _____ _____		
	D. Provision for individual team member counseling;	1 2 3 4 5 6	
	E. Provision for group interaction.	1 2 3 4 5 6	
2.2.2	The hospice program director or designee(s) is responsible for the ongoing development and implementation of inservice and continuing education.	1 2 3 4 5 6	
	A. Please state the name and title of the person responsible for inservice and continuing education: _____		
2.2.3	The team inservice and education programs include, but are not limited to the following:		
	A. Integration of the results of quality assurance activities;	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.2.3	B. Response to stated requests of team members;	1 2 3 4 5 6	
	C. Opportunities for team members to participate in education programs such as workshops, institutes, and formal continuing education;	1 2 3 4 5 6	
	D. A mechanism for evaluating at least annually the effectiveness of team inservice and continuing education.	1 2 3 4 5 6	

Documentation Requested During Survey:

- Written program policy stating the team support program.
- Job description and qualifications of the individual providing team support.
- List of inservice and continuing education activities of the past six months, and how topics were determined.
- Indicate how staff team members become aware of other education opportunities.
- Evaluation mechanism for inservice and continuing education programs.

Goal III: Physician services are provided by an attending physician selected by the patient who is primarily responsible for the care of that patient; and by a designated hospice medical director in accordance with hospice program policy.

Recommended Completion by: The hospice medical director.

Completed by and title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.3.1	The care of every patient/family receiving hospice services is under the supervision of a licensed physician who prescribes a regimen of care.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.3.2	There is a written evidence of the approval by signature of the interdisciplinary team care plan by the attending physician.	1 2 3 4 5 6	
2.3.3	Each attending physician requesting hospice services is responsible for abiding by the policies and procedures of the program which include, but are not limited to the following:		
	A. Admission of patient/families only in accordance with established criteria;	1 2 3 4 5 6	
	B. Prior to or upon admission of a patient/family provision by the physician of information pertaining to at least the following:		
	a. Admitting diagnosis and prognosis;	1 2 3 4 5 6	
	b. Summary of current medical findings, including specific reference to pain and symptom management;		
	c. Diet or nutritional requirements;	1 2 3 4 5 6	
	d. Medication and treatment orders;	1 2 3 4 5 6	
	e. Pertinent orders regarding the the patient's terminal condition;	1 2 3 4 5 6	
	f. A history and physical examination.	1 2 3 4 5 6	
	C. Designation of an alternate physician to contact regarding regular or emergency care of a patient when the attending physician is not available.	1 2 3 4 5 6	
2.3.4	There is documentation of ongoing communication between the attending physician and the team members.	1 2 3 4 5 6	
2.3.5	The hospice medical director is appointed by program director with approval of the governing body.	1 2 3 4 5 6	
2.3.6	The medical director is a licensed physician who is knowledgeable of hospice services, the psychosocial care of patients and families, and the care of advanced irreverisible disease especially in regard to pain and symptom management.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

A. The hospice medical director is currently licensed in your state. ____ Yes ____ No

B. Briefly state his/her qualifications: _____

_____

C. The medical directior is: (Please check one)
_____ Full time; or
_____ part time; or
_____ a volunteer; or
_____ under contract (indicate hrs/week _____ hr/week); or
_____ a committee of physicians whose chairperson provides medical direction with the committee's guidance.

2.3.7 The duties and responsibilities of the medical director include, but are not limited to:

A. Consultation to attending physicians as requested regarding pain and symptom management; 1 2 3 4 5 6

B. Determination of patient medical eligibility for hospice services in accordance with program admission criteria; 1 2 3 4 5 6

C. Acts as a medical resource to the interdisciplinary team; 1 2 3 4 5 6

D. Coordinates efforts with the attending physician to provide care in the event the attending physician is unable to retain responsibility for patient care; 1 2 3 4 5 6

E. Medical liasion with community physicians. 1 2 3 4 5 6

Documentation During Survey

- Medical records
- Job Description and Qualifications of the Medical Director

Goal IV: Qualified individuals provide nursing services which are consistent with high standards of performance and conduct, and with currently available knowledge and nursing skills with attention to the physical, psychosocial, and interpersonal needs of patient/families.

Recommended completion by: The nursing services supervisor, or a nursing team member.

Completed by and title: _____

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

2.4.1 Nursing services are provided by (please indicate the number of F.T.E's)

_____ Full time; and/or
_____ part time; and/or
_____ volunteers; and/or
_____ contracted personnel (indicate hrs/week _____ hrs/week).

2.4.2 Please state briefly the entry level education and experience your program requires for:
RN's _____

_____

LPN's: _____

_____

2.4.3 The hospice program director designates a qualified registered nurse to supervise nursing services.

A. Please state the title, name, and education and experience of the supervisor of nursing services. _____

_____

_____

2.4.4. There is written policy and procedure stating the scope, provision, and documentation of services.

2.4.5 The provision of nursing services is documented and: 1 2 3 4 5 6

A. Is based on a nursing assessment of the patient's physical condition; and 1 2 3 4 5 6

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.4.5.	B. The psychosocial needs of the patient and the family;	1 2 3 4 5 6	
	C. Is goal-directed reflecting observations, actions, and plans;	1 2 3 4 5 6	
	D. Is in accordance with the interdisciplinary team care plan; and	1 2 3 4 5 6	
	E. is submitted in a timely manner in accordance with program policy.	1 2 3 4 5 6	
2.4.6	There is evidence of a current valid license for each individual providing nursing services.	1 2 3 4 5 6	

Documentation During Survey

- Policy and Procedures for nursing services.
- Job description and qualifications of the Nursing Supervisor.
- Medical Records
- Personnel files for nursing team members.

Goal V: Qualified personnel provide psychosocial support services to patients, their families, and to other persons significant to the patient.

Recommended completion by: The psychosocial support service supervisor, or a team member providing psychosocial support.

Completed by and title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.5.1	A. Briefly state the entry level requirements by degree and experience: _____		

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

2.5.1 B. Please indicate the number of persons with the following education giving psychosocial support services:

_____ Less than a BA

_____ BSW

_____ Psychology

_____ Sociology

_____ Other, please indicate

_____

_____ MSW

MA _____ Psychology

_____ Guidance & Counseling

_____ Other, please indicate

_____ PhD Please indicate

_____

_____

2.5.2 Psychosocial support services are provided by (Please indicate number of F.T.E.'s):

_____ full time; and/or

_____ part time; and/or

_____ volunteers; and/or

_____ contracted personnel (indicate hrs/week _____ hr/week).

2.5.3. The hospice program director designates a qualified individual to coordinate psychosocial support services and to provide direct supervision to psychosocial support team members.

1 2 3 4 5 6

A. Please indicate the name, title, and education level of the individual providing coordination and supervision of psychosocial support services;

_____

_____

_____

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

2.5.3 B. This individual is:
(please check one)

_____ Full time _____ Part time _____ Volunteer _____ Contracted

2.5.4	There is written policy and procedure stating the scope, provision, and documentation of psychosocial support services.	1 2 3 4 5 6
2.5.5	The provision of psychosocial support services is documented and:	1 2 3 4 5 6
	A. Is based on a psychosocial assessment of the patient and the family;	1 2 3 4 5 6
	B. Indicates a plan for intervention that is goal directed reflecting observations, actions, and plans;	1 2 3 4 5 6
	C. Is in accordance with the interdisciplinary team care plan; and	1 2 3 4 5 6
	D. is submitted timely in accordance with program policy.	1 2 3 4 5 6
2.5.6	In accordance with state law, a current valid license or certification is held by each individual providing psychosocial support services.	1 2 3 4 5 6

Documentation During Survey

- Policy and procedures for psychosocial support services.
- Job description, qualifications, and as applicable the contract for the supervisor.
- Medical Records
- State requirements, if any, for delivery of psychosocial support services, and if applicable personnel records.

Goal VI: Spiritual services are available in accordance with the needs of the patients and the families.

Recommended completion by: The program spiritual counselor, chaplain, or individual providing spiritual services.

Completed by and title: _____

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

2.6.1 Hospice spiritual services are provided by: (please check all that apply and indicate number in F.T.E.'s)

_____ full time; and/or

_____ part time; and/or

_____ volunteer; and/or

_____ contracted personnel (indicate hrs/week _____hrs/week; and/or

_____ arrangement with local clergy and spiritual counselors.

2.6.2 The responsibilities of the spiritual services program include but are not limited to:

A. Spiritual counseling to assure patients and families are offered spiritual care in keeping with their belief system; 1 2 3 4 5 6

B. Advocacy in contacting appropriate clergy or spiritual counselors in the community and supporting the family's spiritual counselor; 1 2 3 4 5 6

C. Counsultation and education to patients, families, and team members as requested. 1 2 3 4 5 6

2.6.3 There are written policies and procedures stating the scope, provision, and documentation of spiritual services. 1 2 3 4 5 6

2.6.4 The provision of spiritual services is documented and:

A. is consistent with the interdisciplinary team care plan; and 1 2 3 4 5 6

B. is submitted timely in accordance with program policy. 1 2 3 4 5 6

Goal VII: Volunteers who have received training and orientation provide defined lay and professional services under the supervision of a designated, qualified, and experienced staff member.

Recommended completion by: The individual supervising volunteer services.

Completed by and title: _____

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
2.7.1	The objectives and scope of the volunteer services are clearly stated in writing.	1 2 3 4 5 6	
2.7.2	The hospice program director designates an appropriate and qualified individual to select and evaluate volunteers, and coordinate volunteer services. A. State the name, title and briefly experience and education of this individual: _____	1 2 3 4 5 6	
2.7.3	The coordination of volunteer services is stated in writing and includes but is not limited to the following:		
	A. Determination of the need for volunteer services in accordance with the interdisciplinary team care plan;	1 2 3 4 5 6	
	B. Planning and implementing a program for volunteer recruitment;	1 2 3 4 5 6	
	C. Placing volunteers in appropriate services and with patient/families;	1 2 3 4 5 6	
	D. Implementing a volunteer training program;	1 2 3 4 5 6	
	E. Instructing team members on the proper and effective use of volunteer services;	1 2 3 4 5 6	
	F. Keeping team members and the community informed of volunteer services and activities;	1 2 3 4 5 6	
	G. Providing regular programs of continuing education and training specific to volunteer needs.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
2.7.4 An orientation and training program is conducted for volunteers which includes but is not limited to the following:		
A. Orientation to the program's goals and services;	1 2 3 4 5 6	
B. Confidentiality, and protecting patient's/family's rights;	1 2 3 4 5 6	
C. Procedures for responding to unexpected events including incidents, emergencies, and presence at death;	1 2 3 4 5 6	
D. Explanation of the program's method of communication with other team members, and the distinction between administrative and clinical authority and responsibility;	1 2 3 4 5 6	
E. General clinical orientation to the physiological and psychological aspects of terminal disease;	1 2 3 4 5 6	
F. General orientation to family dynamics, coping mechanisms, and psychosocial issues surrounding terminal disease, death, and bereavement;	1 2 3 4 5 6	
G. General communication skills for use with the patient/family;	1 2 3 4 5 6	
H. Discussion of personal issues relating to death and dying.	1 2 3 4 5 6	
2.7.5 A volunteer support program is developed, adopted, and maintained to provide volunteers with individual and group interchange, guidance, and emotional support.	1 2 3 4 5 6	
2.7.6 Volunteers are supervised by an appropriate person designated by the volunteer coordinator in accordance with hospice program policy.	1 2 3 4 5 6	
2.7.7 The following minimum volunteer records are maintained by the hospice program:		
A. A record for each volunteer that includes the volunteer application, record of assignment, and performance evaluation;	1 2 3 4 5 6	
B. A master assignment schedule for all volunteers.	1 2 3 4 5 6	
2.7.8 The following minimum information concerning volunteer services is included in the medical record:		

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.7.8	A. Name of the volunteer providing services;	1 2 3 4 5 6	
	B. Date(s) of services provided:	1 2 3 4 5 6	
	C. Type or activity, of service provided;	1 2 3 4 5 6	
	D. Any patient or family reaction, incident, or change noted.	1 2 3 4 5 6	
2.7.9	There is written policy and procedure stating that the volunteers can provide direct care only:		
	A. With the approval of the attending physician;	1 2 3 4 5 6	
	B. When care is consistent with the interdisciplinary care plan;	1 2 3 4 5 6	
	C. With the patient's and the family's approval.	1 2 3 4 5 6	
	D. When the training and experience of the volunteer is appropriate to the service performed and when the volunteer's services and activities are commensurate with those defined for his or her discipline in the corresponding goals and characteristics of the Hospices Standards Manual;	1 2 3 4 5 6	
	E. With the documentation of the health status as prescribed by applicable legal requirements for volunteers involved indirect patient and care.	1 2 3 4 5 6	

Documentation Requested During Survey

- Policy and procedures of volunteer services.
- Job description and qualifications of the individual coordinating volunteer services.
- Outline of the screening, selection, and training process for volunteers.
- Volunteer personnel and service records

Goal VIII: A qualified individual provides bereavement services that are consistent with current knowledge and skills. Bereavement services are available to survivors for at least one year after the death of a patient.

Recommended completion by: The bereavement supervisor or person providing bereavement care.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.8.1	Bereavement services are provided by: (please check all that apply and indicate number in F.T.E.'s) _____ full time; and/or _____ part time; and/or _____ contracted personnel (indicate hrs/week____hrs/week; and/or _____ interdisciplinary team members.		
2.8.2	The individual providing bereavement services has an understanding of basic family and individual counseling regarding the dynamics of grief and bereavement, and of the symptoms of pathological grief response.	1 2 3 4 5 6	
2.8.3	The bereavement counselor, according to the individual's training and experience, has access to advanced psychological and/or psychiatric consultation and supervision.	1 2 3 4 5 6	
2.8.4	State the name and title of the individual(s) providing bereavement services: _____ A. Briefly indicate the education and training required at entry level for bereavement services: _____ _____ B. Briefly state the training and experience of this individual: _____ _____ _____		
2.8.6	There are written policies and procedures stating the scope, provision and documentation of bereavement services.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.8.7	Bereavement services include but are not limited to:		
	A. A program for regular survivor contact in the twelve months following the patient's death;	1 2 3 4 5 6	
	B. A process of interchange of information between the team members providing care before death and the bereavement counselor;	1 2 3 4 5 6	
	C. Assessment of the needs of the bereaved both before and after death;	1 2 3 4 5 6	
	D. Development and maintenance of programs and resources to meet the needs of the bereaved;	1 2 3 4 5 6	
	E. A process for the assessment of grief reactions that indicate the need for prolonged intervention, or appear to be pathlogical and appropriate for referal;	1 2 3 4 5 6	
	F. Support to team members and family members to participate in meaningful formal services and/or rituals.	1 2 3 4 5 6	
2.8.8	The provision of bereavement services is documented and:	1 2 3 4 5 6	
	A. Is based on an assessment of the needs and the grief of the survivors;	1 2 3 4 5 6	
	B. The follow up is based on a plan for intervention as agreed upon with the survivors;	1 2 3 4 5 6	
	C. Is submitted timely in accordance with hospice program policy.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey:

- Policy and Procedures for bereavement services.
- Job descriptions and qualifications of team members and supervisor.
- Medical records.

Goal IX: Additional services are provided to patients and to families under arrangement or on a consultation basis as deemed necessary in the interdisciplinary team plan or care.

Recommended completion by: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.9.1	There are written policies and procedures that describe the conditions under which referrals are made and the services provided. These conditions provide for but are not limited to the following:	1 2 3 4 5 6	
	A. Examinations, assessments, or consultations that are not within the professional expertise of the primary team members;	1 2 3 4 5 6	
	B. Please list services which you currently can provide as needed:		
	____ Physical therapy ____ Occupational therapy ____ Speech therapy		
	____ Dietary ____ Pharmacy ____ Other, please indicate		
2.9.2	There is written policy and procedure to assure continuity of care which includes, but is not limited to the following:	1 2 3 4 5 6	
	A. The exchange of treatment goals and the interdisciplinary plan of care, and of	1 2 3 4 5 6	
	B. Patient/family psychosocial information;	1 2 3 4 5 6	
	C. Method for communication with interdisciplinary team members providing care and documentation of contract;	1 2 3 4 5 6	
	D. Timely submission of documentation of services provided.	1 2 3 4 5 6	

Goal IX: Additional services are provided to patients and to families under arrangement or on a consultation basis as deemed necessary in the interdisciplinary team plan or care.

Recommended completion by: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.9.1	There are written policies and procedures that describe the conditions under which referrals are made and the services provided. These conditions provide for but are not limited to the following:	1 2 3 4 5 6	
	A. Examinations, assessments, or consultations that are not within the professional expertise of the primary team members;	1 2 3 4 5 6	
	B. Please list services which you currently can provide as needed:		
	____ Physical therapy ____ Occupational therapy ____ Speech therapy		
	____ Dietary ____ Pharmacy ____ Other, please indicate		
2.9.2	There is written policy and procedure to assure continuity of care which includes, but is not limited to the following:	1 2 3 4 5 6	
	A. The exchange of treatment goals and the interdisciplinary plan of care, and of	1 2 3 4 5 6	
	B. Patient/family psychosocial information;	1 2 3 4 5 6	
	C. Method for communication with interdisciplinary team members providing care and documentation of contract;	1 2 3 4 5 6	
	D. Timely submission of documentation of services provided.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
2.9.3	There is written policy and procedure stating how a patient and family may request additional services or consultation which includes but is not limited to:	1 2 3 4 5 6	
	A. A description of the role of the team member in assisting the patient and/or family to seek and receive services the program does not provide.	1 2 3 4 5 6	

DOCUMENTATION requested.

- Policy and procedures for providing additional services.
- Any contracts or written arrangements for said services as applicable.
- Medical records.

HOSPICE PROJECT
SELF ASSESSMENT AND SURVEY GUIDE

SYMPTOM MANAGEMENT

Goal I: Pain and symptom management is provided through appropriate therapies.

Recommended completion by: The hospice program director, team coordinator, or medical director.

Completed by and title: _____

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	DATA BASE
3.1.1	Pain and Symptom management is documented in the care plan and in progress notes throughout the course of patient care and across disciplines.	1 2 3 4 5 6	
3.1.2	The following elements of pain and symptom management are documented:		
	A. Physical assessment;	1 2 3 4 5 6	
	B. Chronic, or acute pain, or change in pain;	1 2 3 4 5 6	
	C. Symptoms associated with pain and pain management;	1 2 3 4 5 6	
	D. Interdisciplinary team communication and consultation with the attending physician;	1 2 3 4 5 6	
	E. Instruction of patients and families regarding pain management and therapies used;	1 2 3 4 5 6	
	F. Repeated assessment of pain and symptoms including determination of compliance with the intervention prescribed.	1 2 3 4 5 6	
3.1.3	There are education programs for the introduction and review of effective pain and symptom assessment and management available to hospice program staff at least twice annually.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	DATA BASE
3.1.4	The programs include but are not limited to the following elements:		
	A. Discussion of approaches to analgesia including non-invasive approaches;	1 2 3 4 5 6	
	B. The use of opiates and their side effects and management;	1 2 3 4 5 6	
	C. Means of assessment of pain and symptoms.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Medical Records.
- Evidence of education, program, and records noting participants and disciplines.

Goal II: Symptom management includes assessing and responding to the emotional, social, and spiritual needs of the patient and the family.

Recommended completion by: The hospice program director or team coordinator.

Completed by and title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	DATA BASE
3.2.1	Psychosocial assessment and intervention is documented in the care plan and in progress notes throughout the course of patient/family care and across disciplines.	1 2 3 4 5 6	
3.2.2	The following elements of psychosocial assessment and intervention are documented:		
	A. Patient and or family symptoms, such as depression, anxiety, etc;	1 2 3 4 5 6	
	B. The patient's and the family's understanding of the illness;		
	C. Notation of family dynamics;	1 2 3 4 5 6	
	D. Interdisciplinary team communication and consultation with the attending physician;	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	DATA BASE
3.2.2	E. Repeated assessment and intervention.		
3.2.3	There are education programs for the introduction and review of psychosocial assessment and intervention available to hospice program staff at least twice annually.	1 2 3 4 5 6	
3.2.4	The education program includes, but is not limited to:		
	A. Basic aspects of psychosocial assessment;	1 2 3 4 5 6	
	B. Patient and family response to terminal illness, death, and family response to bereavement.		
	C. Basic communication skills.	1 2 3 4 5 6	

DOCUMENTATION Requested upon intervention

- Medical records
- Evidence of education programs including subjects presented and records noting participants and disciplines.

HOSPICE PROJECT
SELF ASSESSMENT AND SURVEY GUIDE

HOME CARE AND INPATIENT CARE

Goal I: Hospice program services include home care and inpatient care. The home care and inpatient care services are organized, managed, staffed with a sufficient number of personnel, and appropriately integrated with other services of the program.

Recommended completion by: The hospice program director or the coordinator(s) of the home care and/or inpatient care services.

Completed by and Title: _____

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
4.1.1	There is a written statement of the philosophy and objectives of the home care and of the inpatient care services which includes a description of the services offered in both care settings.	1 2 3 4 5 6	
4.1.2	All applicable local, state, and federal regulations, and/or licensure and certification requirements are met by:		
	A. the home care service;	1 2 3 4 5 6	
	B. the inpatient care service;	1 2 3 4 5 6	
4.1.3	There are written policies and procedures for the home care and the inpatient care services that include, but are not limited to the following:		
	A. The qualifications of the physicians who provide care to the patient/ families admitted to the program;	1 2 3 4 5 6	
	B. The treatment modalities provided including IV's, parenteral feedings chemotheraphy, and the regular administration of injections;	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

C. Approval by an appropriate professional education organization of hospice service training programs; 1 2 3 4 5 6

1. Supervision of students and other trainees when performing patient care by the appropriately qualified hospice personnel; 1 2 3 4 5 6

2. Definition of the respective roles and responsibilities of the hospice program and the outside educational program are defined in writing when the hospice service provides the education and training of students of an outside training program;

D. Designation of tasks that are performed by home health technicians, home health aides, nurses aides, and homemakers respectively. 1 2 3 4 5 6

1. These personnel have satisfactorily completed a structured or on-the-job training program if such instruction is consistent with legal requirements applicable to the hospice program services. 1 2 3 4 5 6

a. There are current requirements for the training of (Please check all that apply).

____ 1. home health technicians;

____ 2. home health aides;

____ 3. homemakers

____ 4. nurses aides.

4.1.4 The hospice program director designates a coordinator of the home care and/or inpatient care services who has the responsibility for providing administrative direction to the home care and/or inpatient care services. 1 2 3 4 5 6

A. State the name and title of the coordinator of the home care services:

_____

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

B. Briefly state the minimum educations and experience required for this position. _____

_____

C. Briefly state the education and training of the current coordinator. _____

_____

D. State the name and title of the coordinator of inpatient care services. _____

E. Briefly state the minimum education and experience required for this position. _____

_____

F. Briefly state the qualifications of the current coordinator. _____

_____

4.1.5 There is a written statement in accordance with hospice program policy of the authorities, duties, and responsibilities of the coordinator which include, but are not limited to the following:

A. Implementation of policies and procedures pertinent to the home care and/or inpatient care settings; 1 2 3 4 5 6

B. Advisor to the program director; 1 2 3 4 5 6

C. Direction and as appropriate supervision of home care and inpatient care team members in their duties;

D. Participation in the review and the evaluation of the quality and appropriateness of patient/family care; 1 2 3 4 5 6

E. Preparation and submission of defined program service reports which include:

1. statistical records of the quantity and types of services rendered; 1 2 3 4 5 6
2. records and reports reflecting the nature of the patient population. 1 2 3 4 5 6

F. Authorization of expenditures for the operation of the services; 1 2 3 4 5 6

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

4.1.6 The number, education, and training of qualified personnel relates realistically to the scope of services provided, the utilization of services, and the level of care indicated by patient case mix in the home care service and in the inpatient care service. 1 2 3 4 5 6

A. Please indicate the following patient/staff ratios as determined by the hospice program for the home care service:
   1. Nursing service: RN ratio _____
      LPN ratio _____
   2. Psychosocial support service: ratio _____
   3. Home health aide/technician: ratio _____

B. Please indicate the following service hrs/patient ratios as determined by the hospice program for the inpatient care services:
   1. Nursing service: RN ratio _____
   2. LPN ratio _____
   3. Psychosocial support service: ratio _____
   4. Nurses aide: ratio _____

DOCUMENTATION Requested During Survey

- Statement of philosophy and objectives.
- Evidence of compliance with all applicable regulation, licensure, and certification requirements.
- Policy and procedures relating to home care and inpatient care general service delivery.
- Job descriptions and qualifications of the home care and/or inpatient care coordinator(s).
- A statement defining the methodology use to determine the above staff/patient ratios.

Goal II: Home care services are available twenty-four hours a day, seven days a week.

Recommended completion by: The hospice program director or the home care service coordinator.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.2.1	There is written policy and procedure stating the scope of services and the documentation of home care services which includes but is not limited to the following:		
	A. Statement of what services are available on a 24hr basis, seven days a week, including access to pharmacy services;	1 2 3 4 5 6	
	1. Please list the services: _____		
	B. Statement of any limitations regarding care provided after normal working hours or on the weekends;	1 2 3 4 5 6	
	C. Method of information exchange between on-call and day-to-day team members.	1 2 3 4 5 6	
4.2.2	Unless otherwise provided by law, at least nursing services are available on a 24 hour basis, seven days a week.	1 2 3 4 5 6	

DOCUMENTATION Requested for Survey

- Policy and procedure regarding twenty four hour care.
- Medical records.

Goal III: Interdisciplinary team members are prepared to provide effective care of the patient and of the family at the time of the patient's death at home.

Recommended completion by: The hospice program director or the home care service coordinator

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
4.3.1 There is a written plan of orientation and inservice training for team members that includes, but is not limited to:		
A. State and local law, regulations, and procedures regarding death in the home and the role of the attending physician;	1 2 3 4 5 6	
B. A procedure for working with the coroner's office and as applicable with law enforcement officials;	1 2 3 4 5 6	
C. Program policy with regard to living wills, do not resuscitate orders, etc. and the respective patient family and attending physician involvement.	1 2 3 4 5 6	

DOCUMENTATION Requested during Survey

- Orientation and/or inservice program outline and notation of participants.
- Medical records.

Goal IV: The inpatient facility or unit has an organized medical staff.

Recommended completion by: The hospice program director or by the medical director.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
4.4.1 The medical staff is accountable to patients/families and the governing body for the quality of medical care provided and for the ethical and professional practice of its members.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.4.2	The medical staff with the assistance of the medical director, and the hospice program director, formulate bylaws and rules and regulations necessary for the self-government and the discharge of the medical staff's responsibilities. The bylaws and rules and regulations include, but are not limited to, the following:	1 2 3 4 5 6	
	A. A descriptive outline of the medical staff organization;	1 2 3 4 5 6	
	B. A statement of the necessary qualifications that physicians must have to be privileged to attend patients in the facility or unit;	1 2 3 4 5 6	
	C. A procedure for granting and withdrawing physician's practice privileges;	1 2 3 4 5 6	
	D. Provisions for regular meetings of the medical staff;	1 2 3 4 5 6	
	E. Provisions for keeping accurate and complete medical records including signed progress notes at each visit and all orders given since the last visit;	1 2 3 4 5 6	
	F. Provisions for securing emergency medical care if the attending physician is not available;	1 2 3 4 5 6	
	G. Provisions that require a physician's written orders to be recorded and signed; and require a physician's verbal and telephone orders to be recorded immediately and signed by the accepting physician, nurse, or pharmacist (in the case of medication orders) and counter-signed by the attending physician;	1 2 3 4 5 6	
	H. A statement of the necessary qualifications, staff appointments, and rights of dentists, podiatrists, psychologists, nurse practitioners, physician assistants and health professions;	1 2 3 4 5 6	
	I. Provisions for the establishment of effective controls throughout the medical staff organization to assure achievement and maintenance of maximum standards of ethical and professional practices;	1 2 3 4 5 6	
	J. Provisions for a fair hearing in the event of denial of staff appointment or reappointment or the curtailment, suspension, or revocation of privileges;	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.4.2	K. Provisions for review and evaluation of the quality of services rendered, including appropriateness of attending physician visit schedules;	1 2 3 4 5 6	
	L. A procedure for physician contact and care when either the attending physician or the designated alternate are not available to examine and treat a patient needing immediate attention.	1 2 3 4 5 6	
	M. Other provisions that the medical staff determines will be effective in their local community.	1 2 3 4 5 6	
4.4.3	The duties and responsibilities of the medical director of the inpatient care care services includes direction of the medical care in the facility or unit.	1 2 3 4 5 6	

Goal V: Physical provision is made in the inpatient care setting for the privacy of the patient/family.

Recommended completion by: The hospice program director or inpatient care coordinator.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.5.1	There is physical space provided for private patient/family visiting.	1 2 3 4 5 6	
4.5.2	There are accomodations for family members to remain through the night with the patient.	1 2 3 4 5 6	
4.5.3	There is space provided for family viewing and privacy after the patient's death.	1 2 3 4 5 6	

DOCUMENTATION Requested for During Survey

- Tour of the unit or facility.

Goal VI: The inpatient facility or unit is designed, constructed, equipped, and furnished in a manner that assures the physical safety of patients, family, personnel, and visitors.

Recommended completion by: The hospice program director or hospice physical plant representative.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
4.6.1 The building complies with the the 1981 edition of the Life Safety Code, of the National Fire Protection Association (NFPA). The following is required:		
A. Submission of a statement of construction and fire protection. This document is completed by the facility or unit. The information entered in the document is verified and authenticated by a qualified individual who is knowledgeable in institutional construction and fire safety, particularly in regard to health care facilities. Individuals who may verify and authenticate include registered professional engineers, registered architects, members of the Society of Fire Protection Engineers, or qualified employees of either a fire insurance rating organization or the office of the state fire marshal. It is strongly recommended that such verification or authtication be made following an on-site visit by the above individual.	1 2 3 4 5 6	
B. A plan of correction for all physical plant deficiencies is identified by authorized inspecting agencies and/or indicated in the Statement of Construction and Fire Protection. This plan of correction is approved by the authority having jurisdiction and specifies the anticipated time of completion.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
C. A document exists that certifies that the facility's physical plan is in compliance with the requirements of the 1981 Life Safety Code. This documentation may include copies of the state fire marshal's report, state licensure survey reports, or reports of other authorized agencies. Consideration is also given to equivalency when an element of safety is provided at a level equal to or greater than that described in the codes, provided that no other safety element or system is compromised or adversely altered in any way. When alternate protection has been installed and has been accepted by the local authority having jurisdiction, appropriate documentation is required. Copies of all such documentation are available.	1 2 3 4 5 6	
D. If the building is constructed prior to 1973 and the requirements of the standards or their equivalency are not met, the facility institutes and documents on a sustained basis extraordinary fire prevention measures in the form of effective housekeeping and maintenance practices, provision of adequate fire fighting equipment, adequate staffing, and frequent fire drills on all shifts.	1 2 3 4 5 6	

DOCUMENTATION to certify compliance with Life Safety Code.

Goal VII: The facility ensures the provision of an adequate and comfortable enviornment that is accessible and provides sufficient space and equipment for clinical care and personal care of the patients.

Recommended completion by: The inpatient care coordinator or physical plant representative.

Completed by and Title: _____

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
4.7.1	The provision of adequate and comfortable lighting levels in all areas, limitation of sounds to comfort levels, maintenance of a comfortable room temperature and the adequacy of ventilation through windows, mechanical means, or a combination of both.	1 2 3 4 5 6	
4.7.2	In the event of the loss of normal water supply provision is made to assure that water is available to all essential areas.	1 2 3 4 5 6	
4.7.3	The facility is accessible to and functional for physically handicapped patients/families, staff, and visitors. Reasonable accomadations are made in accordance with American National Standards Institute (ANSI) Standard A1117.1, Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped.		
4.7.4	Each patient/family care unit has at least but is not limited to, the following:		
	A. Nurses' station;	1 2 3 4 5 6	
	B. Drug storage and preparation areas; and	1 2 3 4 5 6	
	C. Utility and storage rooms.	1 2 3 4 5 6	
4.7.5	The nurses' station is equipped to register patient's/families' calls through a communication system from patient/family areas, including patient/family rooms and toilet and bathing facilities.	1 2 3 4 5 6	
4.7.6	Patient/family rooms are designed, equipped, and furnished to comply with all applicable federal, state, and local laws and rules and regulations as well as to facilitate effective patient/family care and comfort.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITEREA		RATING	BASE DATA
4.7.7	Each room is equipped with, convenient to, or located near, toilet and bathing facilities.	1 2 3 4 5 6	
4.7.8	Each room has direct access to a corridor and outside exposure, with the floor at or above ground level.	1 2 3 4 5 6	

DOCUMENTATION Requested during Survey

- Tour of unit or facility.
- (Hospice inpatient care servcies located in hospitals are subject to the Buildings and Gound Safety standards currently applicable to the hospital.)

Goal VIII: The inpatient facility or unit provides an enviornment that is functionally safe and sanitary for patients/families, staff, and visitors.

Recommended completion by: The inpatient care coordinator or the person responsible for the inpatient safety program.

Completed by and Title:_____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.8.1	The hospice program director or designee(s) implements and monitors a comprehensive facility-wide or unit-wide safety program which is appropriate to the size of the facility or unit.	1 2 3 4 5 6	
4.8.2	The inpatient care staff, and other personnel as appropriate, are utilized in the development, implementation, and monitoring of safety characteristics and practices to eliminate or reduce hazards to patients/families.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.8.3	The safety program includes written policy and procedures:		
	A. To enhance safety within the facility or unit and on the facility's gounds; to	1 2 3 4 5 6	
	B. Coordinate the development of department service safety rules and practices; to	1 2 3 4 5 6	
	C. Establish an incident reporting system that includes a mechanism for investigating and evaluating all incidents reported and for documenting the review of all such reports and actions taken; to	1 2 3 4 5 6	
	D. Establish liaison with the infection control committee; to	1 2 3 4 5 6	
	E. Provide safety-related information to be used in the orientation of all staff and volunteers; to	1 2 3 4 5 6	
	F. Conduct hazard surveillance programs at specifically defined intervals; to	1 2 3 4 5 6	
	G. Establish methods for measuring results of the safety program and for periodic analysis to determine its effectiveness, which includes review of all pertinent records and reports; to	1 2 3 4 5 6	
	H. Familiarize the facility or unit with applicable federal, state, and local safety regulations.	1 2 3 4 5 6	
4.8.4	The facility or unit has an available emergency power source that provides essential service when normal electrical supply is interrupted.	1 2 3 4 5 6	
4.8.5	Comprehensive safety devices are installed and safety practices, policies, and procedures are instituted to minimize hazards to patients/families, staff, and visitors.	1 2 3 4 5 6	
4.8.6	The facility or unit has a written internal disaster and fire plan, and fire drills.	1 2 3 4 5 6	
4.8.7	Sanitation practices, policies, and procedures are implemented to minimize health hazards to all patients/families, staff and visitors.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Safety program outline and policy and procedures
- (Hospice inpatient services provided in a hospital are subject to the Functional Safety and Sanitation standards of the hospital.)

Goal IX: There is an active facility-wide or unit-wide infection control program.

Recommended completion by: The hospice program director of designees.

Completed by and Title: _____

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
4.9.1	There is a written plan for the prevention and control of infection and the maintenance of a sanitary environment. The plan includes, but is not limited to the following:	1 2 3 4 5 6	
	A. Designation of multidisciplinary personnel responsible for implementing and monitoring the program;	1 2 3 4 5 6	
	B. Review of procedures for handling food, processing laundry, disposing environmental and patient/family wastes, controlling pests, and controlling traffic;	1 2 3 4 5 6	
	C. Review of patient/family care practices, visiting rules for high risk areas, and sources of infection;	1 2 3 4 5 6	
	D. Monitoring the health status of employees;	1 2 3 4 5 6	
	E. Monitoring staff performance to assure that policies and procedures are being followed.		
4.9.2	There are written policies and procedures for aspetic and isolation techniques.	1 2 3 4 5 6	
	A. These procedures are made known to, and followed by, all staff and are reviewed annually and revised as necessary.	1 2 3 4 5 6	
4.9.3	The facility or unit employees sufficient housekeeping personnel and provides all necessary equipment to maintain a clean, orderly, and safe environment.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.9.4	The facility or unit has sufficient linen available at all times for the proper care and comfort of patients.	1 2 3 4 5 6	
	A. The linen is handled, processed, stored, and transported in a manner that prevents the transmission of infection.	1 2 3 4 5 6	
4.9.5	The facility or unit is free of insects and rodents.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Plan for infection control.
- Tour of facility or unit

Goal X: The inpatient facility or unit provides for the nutritional and special dietary needs of the patients and the psychosocial needs of the patient/families.

Recommended completion by: The hospice program director or director of the dietary services.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.10.1	Safe, sanitary, and adequately equipped facilities are provided for food preparation by patients and families.	1 2 3 4 5 6	
4.10.2	The dietetic services are provided by (please check one)		

____ a service within the facility;

____ Written agreement with another health care facility; or

____ Written contract with an outside food service or management company.

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.10.2	A. If services are provided by contract, the contract or agreement states that the services provided must meet the standards.	1 2 3 4 5 6	
4.10.3	The dietetic service is directed by an individual who by education or specialized training and experience is knowledgeable in foodservice management.	1 2 3 4 5 6	
4.10. 4	The nutritional aspects of patient care are supervised by a qualified dietician who is registered by the Commission on Dietetic Registration of the American Dietetic Association, or has the documented equivalent in education, training, and experience, with evidence of continuing education.	1 2 3 4 5 6	
4.10.5	The duties of the registered dietician include, but are not limited to the following:		
	A. Patient/family consultation;	1 2 3 4 5 6	
	B. Participation in patient/family conferences as requested,	1 2 3 4 5 6	
	C. Approval of menus, including modified diets,	1 2 3 4 5 6	
	D. Nurtitional assessments,	1 2 3 4 5 6	
4.10.6	A qualified dietician provides services (please check one):		
	_____ as a full time; or		
	_____ as a part time; or		
	_____ as a contracted employee (indicate hrs/week___hrs/week); or		
	_____ as a volunteer.		
4.10.7	The dietetic department or service is organized, directed, and staffed to assure the provision of optimal nutritional care and quality foodservice.	1 2 3 4 5 6	
4.10.8	Dietetic personnel are appropriately trained and educated.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.10.9	The dietetic department or service area is designed and equipped to provide safe, sanitary, and timely foodservice and to meet the nutritional needs of patients/families.	1 2 3 4 5 6	
4.10.10	Dietetic services are guided by written policies and procedures.	1 2 3 4 5 6	
4.10.11	Dietetic services are provided to the patients in accordance with a written order by the attending physician, and appropriate dietetic information is recorded in the patient's/family's medical record.	1 2 3 4 5 6	
4.10.12	The quality and appropriateness of the nutritional care in meeting the nurtitional and psychosocial needs of patients/families is regularly reviewed and evaluated. * (Hospice inpatient services provided in hospitals are subject to the Dietetic Services standards currently applicable to the hospital.)	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Policies and procedures relating to dietetic services, including evaluation.
- Job description and qualifications of the
  - dietician
  - director of dietetic service
- Evidence of training and orientation of dietetic personnel.
- Medical records.

Goal XI: The pharmacutical needs of patients are met by the hospice program. (Unless specified for inpatient services only.)

Recommended completion by: The pharmacist or the hospice program director.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.11.1	Only practitioners authorized by law may write medication orders.	1 2 3 4 5 6	
4.11.2	Medication orders that contain abbreviations and chemical symbols are carried out only if the abbreviations and symbols are on a standard list of abbreviations and symbols approved by the medical director and/or medical staff.	1 2 3 4 5 6	
4.11.3	Individuals other than physicians, RN's, or LPN's may administer medications under the supervision of an RN or LPN, if an accordance with applicable laws and regulations and the hospice program policy and if approved by the attending physician.	1 2 3 4 5 6	
4.11.4	Self-administered medication is permitted when specifically ordered for the patient by an approved prescriber in accordance with applicable laws and regulations.	1 2 3 4 5 6	
4.11.5	Before discharge the patient and family are instructed as to which medications if any are to be administered at home and by whom; the preparation and administration, dosages, schedule and precautions to be taken.	1 2 3 4 5 6	
4.11.6	The medications administered, and adverse drug reactions are documented in the medical record and are periodically reviewed by the attending physician.	1 2 3 4 5 6	
4.11.7	There is written policy and procedure regarding medication error follow-up, and documentation of corrective action taken if appropriate.	1 2 3 4 5 6	
4.11.8	There are up-to-date resources available to identify drug side-effects and toxic reactions.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.11.9	There is a reporting system for advising the Food and Drug Administration and the drug manufacturer of any unexpected or significant adverse drug reactions.	1 2 3 4 5 6	
4.11.10	Investigational drugs are used only under the direct supervision of an authorized investigator and with the approval of the medical director, and the Institutional Review Board. (When hospice inpatient services are provided in a hospital, the hospital's procedures regarding investigational drugs supercedes this standard.)	1 2 3 4 5 6	
4.11.11	All medication orders are reviewed in accordance with applicable regulations.	1 2 3 4 5 6	
4.11.12	The pharmacist is experienced in or receives orientation in the specialized functions of the hospice program.	1 2 3 4 5 6	
4.11.13	A pharmacist participates in the development of education programs for the hospice program staff.	1 2 3 4 5 6	
4.11.14	The home care program has evidence of access to medications 24 hrs/7 days a week.	1 2 3 4 5 6	
	The following characteristics are applicable to inpatient services.		
4.11.15	The pharmaceutical service for the inpatient facility or unit is provided through a delineated agreement with any of the following: (Please check all that apply) _____ An outside unit or facility (e.g. hospital pharmacy): ____ A community pharmacy. ____ An organized pharmaceutical service in the facility or on the unit.	1 2 3 4 5 6	

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
4.11.16	A licensed pharmacist experienced in institutional pharmacy practice is responsible for the development of written policies and procedures to govern the safe storage, preparation, distribution, and administration of drugs in accordance with applicable federal, state, and local laws and regulations, regardless of the arrangement made for services.	1 2 3 4 5 6	
4.11.17	A pharmacist makes at least monthly inspections of all drug storage units, including the emergency cart.	1 2 3 4 5 6	
4.11.18	In inpatient facilities or units where pharmaceuticals are provided through a community pharmacy, medications are obtained by written prescription only of an authorized prescriber.	1 2 3 4 5 6	
4.11.19	Drugs brought into the inpatient facility or on to the unit, are not administered unless they can be identified, and unless written orders to administer them are given by the physician responsible for the patient, and they are judged to be physically and chemically stable by the pharmacist.	1 2 3 4 5 6	
4.11.20	The inpatient facility or unit utilizes a drug profile, and a pharmacist regularly reviews the medication records of the patients.	1 2 3 4 5 6	
4.11.21	The inpatient facility or unit has specific policies and procedures for controlling and accounting for drug products. Procedures should account for drugs ordered, on hand, and effectiveness dates.	1 2 3 4 5 6	
4.11.22	Adequate precautions are taken to store medications under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.	1 2 3 4 5 6	
4.11.23	Drug preparation and storage areas are secure and well lighted.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Tour of unit

DOCUMENTATION Requested During Survey

- Medical Records
- Policies and procedures relating to pharmaceutical services

Goal XII: The inpatient facility provides or has delineated access to radiology services for patients.

Recommended completion by: Hospice program director or director of radiology services.

Completed by and Title: _____

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
4.12.1	If radiology services are provided by another facility or unit, please complete, if not proceed to 4.12.2.		
	A. The type of radiology service available and the arrangements for referring and transferring patients is delineated in a written plan.	1 2 3 4 5 6	
4.12.2	When radiology services are provided by the facility or unit:	1 2 3 4 5 6	
	A. Written policies and procedures govern the operation and inspection as stated in applicable regulation;	1 2 3 4 5 6	
	B. Direction is provided by a physician who is a member of the hospital's or facility's medical staff and is qualified through education and/or experience to assume this function;	1 2 3 4 5 6	
	C. Provision is made for appropriate facilities for radiographic and flouroscopic diagnostic services.	1 2 3 4 5 6	
	D. There is an acceptable method of quality control used in radiology services.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Written policies and procedures

DOCUMENTATION Requested During Survey

- Job description and qualifications of director of radiology services.
- Medical records.

Goal XIII: The inpatient facility or unit provides, or has delineated access to pathology and laboratory services in accordance with the needs of the patients, the size of the facility or unit, the services offered, and the resources available in the community.

Recommended completion by: Hospice program director or pathology and laboratory service representative.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.13.1	The means of providing pathology and laboratory services are delineated in a written plan.	1 2 3 4 5 6	
4.13.2	When pathology and laboratory services are provided by the facility or in the unit:		
	A. Written policies and procedures govern the operation;	1 2 3 4 5 6	
	B. Direction is provided by a physician member of the facility or hospital staff who is qualified by education and/or experience to assume this function;	1 2 3 4 5 6	
	C. An acceptable method of quality control is used in the pathology service.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Written policy and procedures

Goal XIV: The inpatient facility or unit has a written plan delineating the manner in which emergency services are provided.

Recommended completion by: Hospice program director or inpatient care service coordinator.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
4.14.1	When emergency services are provided by an outside facility or another unit, the type of emergency services available and the arrangements for referring and transferring patients, families, staff, or visitors are delineated in a written plan.	1 2 3 4 5 6	
4.14.2	When emergency services are provided by a facility or unit, the type of emergency services available are delineated, and the services provided are organized and properly directed.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Written plan, or policy, and procedure.

HOSPICE PROJECT
SELF ASSESSMENT AND SURVEY GUIDE

CONTINUITY OF CARE

Goal I: The hospice program provides a continuum of home care and inpatient care services.

Recommended completion by: The hospice program director or the coordinator(s) of the home care and inpatient care services.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
5.1.1 Hospice home care services are provided through: (Please check all that apply)		
A. _____ A hospice home care agency; or	1 2 3 4 5 6	
B. _____ A unit or designated service of an community home health agency; or	1 2 3 4 5 6	
C. _____ A unit or designated service of a hospital based home health agency;	1 2 3 4 5 6	
5.1.2 Please indicate the number of new admissions to the home care service in the preceeding month:	No. _____ Mo _____/Yr ____	
A. Please state the number of new admissions to the home care service in the month prior to the last:	No. _____ Mo. _____Yr ____	
B. What percentage of your current monthly census has a diagnosis of cancer:	_____%	
C. Please state the number of volunteers currently working with the home care service: a. The number of lay volunteers _____ b. The number of professional volunteers _____	_____	

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

5.1.3 Hospice inpatient care services are provided through: (Please check all that apply)

A. _____ A hospice inpatient facility;

B. _____ An inpatient unit in a

___ a. Hospital;
___ b. Intermediate Care Facility;
___ c. Skilled Nursing facility;

C. _____ A "Scattered bed" or consultation team approach in an acute care hospital. 1 2 3 4 5 6

5.1.4 Are there identified in-patient beds? _____ Yes _____ No

A. Please state the number of beds _____

B. Are the beds only for hospice patients? _____ Yes _____ No

C. Please state the number of admissions to the inpatient care service during the preceeding month: # _____ Mo. _____/Yr. _____

D. Please state the number of admissions to the inpatient care service in the month prior to the last: # _____ Mo. _____/Yr. _____

E. Please state the number of volunteers currently working with the inpatient care service.
a. The number of lay volunteers: _____
b. The number of professional volunteers: _____

5.1.5 If the hospice program does not directly provide both home care services and inpatient care services, there is a written agreement between the hospice program and the provider(s) governing the nature and scope of services, and assuring continuity of care. 1 2 3 4 5 6

A. Please list hospice program services or interdisciplinary team services that are not currently provided directly:

_____

_____

_____

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

5.1.5 _____

_____

5.1.5 B. The written agreement includes, but is not limited to the following:

1.	A statement of what services are provided by each party to the contract;	1 2 3 4 5 6
2.	The qualifications of the personnel providing services;	1 2 3 4 5 6
3.	The role and responsibility of the hospice program in the selection, evaluation, orientation, and continuing education of personnel providing hospice care;	1 2 3 4 5 6
4.	The manner in which services are initiated, coordinated, and evaluated by the hospice program;	1 2 3 4 5 6
5.	The role of the hospice program team members, the provider(s), and the attending physician in the establishment, regular review, and implementation of the care plan;	1 2 3 4 5 6
6.	The requirements for providing documentation of services rendered according to hospice program policy;	1 2 3 4 5 6
7.	A statement that all contracted services must comply with the standards as stated in the Manual;	1 2 3 4 5 6
8.	Compliance of the provider(s) with all applicable federal, state, and local regulations;	1 2 3 4 5 6
9.	A statement of the liability with regard to the limits and responsibility of the program and the provider(s);	1 2 3 4 5 6
10.	The term of the agreement and the basis for its termination or renewal;	1 2 3 4 5 6
11.	Provision for reimbursement for services, if any;	1 2 3 4 5 6
12.	The individual(s) responsible for the implementation of provisions of the agreement is; _____	1 2 3 4 5 6

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
5.1.5 C. If the hospice program at the the time of survey is unable to provide a written agreement for the provision of home care and inpatient care services, there is evidence of at least the following:		
1. There is a written plan to secure a written agreement for hospice services not currently provided directly.	1 2 3 4 5 6	
a. There is supporting documentation of action taken on the plan.	1 2 3 4 5 6	
2. Provision of the interdisciplinary team care plan to the provider(s);	1 2 3 4 5 6	
3. Presentation of orientation and continuing education to identified personnel regarding pain and symptom management, and psychosocial assessment and intervention, as well as general hospice philosophy of care;	1 2 3 4 5 6	
4. Coordination of discharge and transfer planning;	1 2 3 4 5 6	
5. Regular communication between care providers or a designated liasion in accordance with hospice program policy regarding the implementation and review of the care plan;	1 2 3 4 5 6	
6. Exchange of information in accordance with hospice program policy;	1 2 3 4 5 6	
7. Twenty-four hour availability of hospice program consultation to the provider(s).	1 2 3 4 5 6	
5.1.6 There is a written plan regarding the transfer or discharge of patients/families which is applicable to program services whether or not provided directly. The plan includes, but is not limited to the following:	1 2 3 4 5 6	
A. The involvement of team members providing care;	1 2 3 4 5 6	
B. The involvement of the patient and the family in the transfer or discharge decision;	1 2 3 4 5 6	
C. The instruction of the patient and the family members as appropriate before discharge or transfer;	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
5.1.6	D. The delineation of the appropriate medical, clinical, and administrative information to be exchanged in a transfer and the method of change;	1 2 3 4 5 6	
	E. Evidence of the attending physician's concurrence with the transfer or discharge plan indicated by his/her signature.	1 2 3 4 5 6	
5.1.7	There is a policy for the intercommunication between home care service and inpatient care service team members regarding program issues, whether or not the services are provided by the program directly.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Written policy, proceedures and plans regarding provision of a continuum of care for
  - inpatient care services
  - home care services
  - transfer and discharge
- Any contracts or letters of agreement for the provision of hospice services not directly provided by the program.

HOSPICE PROJECT
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MEDICAL RECORDS

Goal I: An accurate medical record which provides documentation of hospice program and interdisciplinary team services, and is readily accessible to permit prompt retrieval of information, is maintained for every patient/family who is provided hospice care.

Recommended completion by: The hospice medical director or individual responsible for the maintenance of medical records.

Completed by and Title: _____

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
6.1.1	The number of patients currently receiving hospice care: A. home care service		# _____ Month _____
	B. inpatient care services		# _____ Month _____
6.1.2	A medical record exists for every patient/family served.	1 2 3 4 5 6	
6.1.3	The medical record is sufficiently detailed and accurate to enable the assumption of care by another interdisciplinary team member.	1 2 3 4 5 6	
6.1.4	There is a standardized medical record format designed according to the requirements of the hospice program.	1 2 3 4 5 6	
	A. The format is used in inpatient care and home care services and to document interdisciplinary team services.	1 2 3 4 5 6	
6.1.5	The medical record of each patient/family provided hospice care includes, but is not limited to:	1 2 3 4 5 6	
	A. Data that identifies the patient/family or an explanation for any missing items of identification;	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA			RATING	BASE DATA
6.1.5	B.	All pertinent diagnoses;	1 2 3 4 5 6	
	C.	The patient's prognosis;	1 2 3 4 5 6	
	D.	Designation of the attending physician;	1 2 3 4 5 6	
	E.	Designation of the primary family member or caregiver to be contacted in the event of an emergency or death;	1 2 3 4 5 6	
	F.	The patient's medical history which may be a copy obtained from the hospital or physician's office with current update added by the attending physician or hospice nurse;	1 2 3 4 5 6	
		1. The findings of a physical examination by the attending physician performed within 24 hours upon admission to the inpatient care service;	1 2 3 4 5 6	
	G.	A current written plan of care which includes a problem list, a statement of goals and types of services and frequency of services to be provided, current medications, diet, treatment, procedures, and equipment required;	1 2 3 4 5 6	
	H.	The patient's functional limitations;	1 2 3 4 5 6	
	I.	Activities permitted;	1 2 3 4 5 6	
	J.	Safety measures required to protect the patient from injury;	1 2 3 4 5 6	
	K.	A physical assessment of the patient and psychosocial assessment of the patient/family;	1 2 3 4 5 6	
	L.	Signed and dated progress notes for each home visit or inpatient service rendered including a description of signs and symptoms, treatment, service, or medication rendered, patient reaction, any change in the patient's condition; and any patient/family instruction given and compliance:	1 2 3 4 5 6	
	M.	Legible and complete diagnostic and therapuetic orders authenticated by the attending physician;	1 2 3 4 5 6	
	N.	Relevant test determinations and procedure findings;	1 2 3 4 5 6	
	O.	Written record of interdisciplinary team conferences;	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
6.1.5	P. Copies of all transfer and summary reports;	1 2 3 4 5 6	
	Q. A bereavement assessment and plan for intervention;	1 2 3 4 5 6	
	R. Instructions as applicable to the patient/family concerning care at discharge;	1 2 3 4 5 6	
	S. Conclusions or evaluation at the termination of hospice care, including copy of a referral if applicable.	1 2 3 4 5 6	
6.1.6	The home care service medical record also includes, but is not limited to the following additional information:		
	A. The name of the person who will assume primary responsibility for the care of the patient at home;	1 2 3 4 5 6	
	B. The suitability or adaptability of the patient's/family's residence for the provision of required medical services.	1 2 3 4 5 6	
6.1.7	The record of a discharged patient/family is completed within a reasonable period of time specified in hospice program policy.	1 2 3 4 5 6	
	A. The time period specified in the policy is: _____		
6.1.8	There is written program policy delineating the authority to make entries in or review the medical record which reflects the duties and responsibilities of the interdisciplinary team.	1 2 3 4 5 6	
6.1.9	Verbal orders of physicians are to be recorded and later authenticated by the attending physician within the time specified in hospice program policy and/or in the bylaws and regulations of the medical staff.	1 2 3 4 5 6	
	A. The time period is: _____		
6.1.10	All entries in the medical record are to be dated and signed with the name and title of the person making the entry. Hospice program policy determines when initials may be used to authenticate an entry.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
6.1.11	The length of time for retaining medical records is recorded in the hospice program policies and procedures. A. The length of time specified is: _____	1 2 3 4 5 6	
6.1.12	There is a coding system and an indexing system used to facilitate retrievability of medical records information for reporting, evaluation, and mointoring activities.	1 2 3 4 5 6	
6.1.13	There are security measures that are reasonable and safeguard both the medical record and its informational content whether in hand copy, on film, or in computerized form, against loss, defacement, tampering, unauthorized disclosure and use by unauthorized persons.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Medical record policy and procedures
- Medical records.

Goal II: There is adequate direction and staffing to maintain medical records.

Recommended completion by: The hospice program director or the person responsible for the maintenance of medical records.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
6.2.1	An individual is appointed by the hospice program director to be responsible for the maintenance of medical records according to hospcie program policy.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

6.2.1 A. State the name and title of the person responsible for maintanence of the medical records: _____

B. Briefly state the training and experience of this individual. _____

_____

6.2.2 The medical records services and personnel are under the direction, or at least twice annual review on a consultative basis, of a qualified medical record professional who has sucessfully completed the examination requirements of the American Medical Record Association or the equivalent. 1 2 3 4 5 6

DOCUMENTATION Requested During Survey

- 1. Job description, qualifications, and if applicable contract for the medical records personnel and/or medical records technician.

HOSPICE PROJECT
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GOVERNING BODY

Goal I: An organized governing body is responsible for establishing policies, and for maintaining high standards of patient care and program management.

Recommended completion by: The president of the board or by the hospice program director.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
7.1.1 The individual, group, corporation, or government agency in which the responsibility and authority for the operation of the hospice program is vested is: _____		
7.1.2 A private, independently or community agency owned hospice program has a charter and/or constitution and bylaws.	1 2 3 4 5 6	
7.1.3 A hospice program that is a component of another facility, institution, or government agency has a written description stating at least the following:		
A. The governing body responsible for the hospice program;	1 2 3 4 5 6	
B. The relationship of the governing body of the facility, institution, or agency to the director of the hospice program;	1 2 3 4 5 6	
C. The authority given to the hospice program specific to:		
1. planning and organization;	1 2 3 4 5 6	
2. program operation;	1 2 3 4 5 6	
3. the hiring, termination, and assigning of hospice program personnel;	1 2 3 4 5 6	
4. policy and procedure adoption and review.	1 2 3 4 5 6	
7.1.4 The bylaws adopted by the governing body are in accordance with its legal accountability.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
7.1.5	The bylaws include, but are not limited to the following:		
	A. Purpose of the hospice program;	1 2 3 4 5 6	
	B. Duties and responsibilities of the governing body;	1 2 3 4 5 6	
	C. Method of selecting members of the governing body and permissible length of service;	1 2 3 4 5 6	
	D. Method of selection of the officers and permissible number of terms that can be served;	1 2 3 4 5 6	
	E. The responsibilities of the officers;	1 2 3 4 5 6	
	F. Meeting procedures, regularity of meetings, definition of "quorum" to conduct business, and attendance policy;	1 2 3 4 5 6	
	G. A list of the committees of the governing body and how they relate to that governing body;	1 2 3 4 5 6	
	H. The composition and responsibilities of the committees;	1 2 3 4 5 6	
	I. The mechanism by which the bylaws are adopted and changed;	1 2 3 4 5 6	
	J. Provision for the regular review and revision of the bylaws and documentation for each process.	1 2 3 4 5 6	
7.1.6	There is a defined mechanism for communication between the governing body and the hospice program administration and the organized medical staff of the inpatient care service.	1 2 3 4 5 6	
7.1.7	The governing body provides for the establishment of auxiliary organizations and approves the bylaws of such organizations.	1 2 3 4 5 6	
7.1.8	A written record of the governing body's and committee's proceedings is maintained and signed by a designated member of the body, committee, or secretary of the governing body.	1 2 3 4 5 6	
7.1.9	There is evidence of community involvement and input through advisory group committees or board membership.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
7.1.10	The capital budget and annual operating budget is adopted by the governing body and its implementation is monitored.	1 2 3 4 5 6	
7.1.11	The governing body appoints the hospice program director, or designates that authority to the appropriate administrative representative in accordance with written institution, policy A. The hospice program director is appointed by;	1 2 3 4 5 6	
7.1.12	There is a defined mechanism to evaluate the governing body's own performance which includes a statement as to the regularity of the review, how it is initiated, and analyzed.	1 2 3 4 5 6	
7.1.13	The governing body reviews and approves the bylaws and regulations of the medical staff of the inpatient care service.	1 2 3 4 5 6	
7.1.14	There are written responsibilities of the governing body which include but are not limited to:		
	A. Approval of the program's goals and objectives;	1 2 3 4 5 6	
	B. Evaluation of the program's performance with regard to its stated purpose, goals and objectives;	1 2 3 4 5 6	
	C. Determination and approval of policies to govern the program;	1 2 3 4 5 6	
	D. Assurance of fiscal solvency and adequacy of financial resources;	1 2 3 4 5 6	
	E. Planning for long term development and maintenance;	1 2 3 4 5 6	
	F. Support for a comprehensive quality assurance program.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Policies and procedures relating to the governing body and the hospice program relationship to the governing body.
- Organizational chart.

Goal II: The governing body avoids conflict of interest.

Recommended Completion by: The president of board or hospice program director.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
7.2.1	There is written disclosure of hospice ownership and control.	1 2 3 4 5 6	
7.2.2	There is a written policy which includes, but is not limited to:		
	A. The method and the content of disclosure by governing body members for review;	1 2 3 4 5 6	
	B. Guidelines for the resolution of any existing conflict of interest within a specific time frame;	1 2 3 4 5 6	
	C. A defined ongoing monitoring mechanism and specified time period for regular review.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Policy and procedure regarding governing body conflict of interest

Goal III: The governing body provides for the orientation of its members.

Recommended completion by: The president of the governing body or the hospice program director.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
7.3.1	There is an orientation program provided for each new governing body member that includes, but is not limited to:		
	A. the board functions and responsibilities;	1 2 3 4 5 6	
	B. the history, services, and purpose of the hospice program.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA

7.3.1 1. The person responsible for the orientation program and its implementation is: _____

_____

DOCUMENTATION Requested During Survey

Plan for orientation and evidence of participation.

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MANAGEMENT AND ADMINISTRATION

Goal I: The hospice program is managed in a manner consistent with the authority and responsibility conferred by the governing body to accomplish the program goals and objectives.

Recommended completion by: The hospice program director.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
8.1.1.	A qualified program director is selected in accordance with hospice program policy.	1 2 3 4 5 6	
	A. The name and title of the program director is: _____		
	B. Briefly state the qualifications, education and experience of the program director: _____		
	C. The hospice program director is selected by: _____		
8.1.2	The hospice program director is: (please check one):		
	_____ A full time; or		
	_____ a part time; or		
	_____ a contracted employee (indicate hrs/week ___hrs/week);		
	_____ or a volunteer.		
8.1.3	The individual designated to act in the program director's absence is: _____		

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
8.1.4	The responsibilities of the program director include, but are not limited, to the following:		
	A. Implementation of policies approved by the governing body;	1 2 3 4 5 6	
	B. Utilization of personnel and resources to achieve the program goals;	1 2 3 4 5 6	
	C. Administration and evaluation of the program and team services;	1 2 3 4 5 6	
	D. Participation with organizations that work to improve the care of the dying.	1 2 3 4 5 6	
8.1.5	There are written plans to guide at least the following:		
	A. Organization of programwide administrative functions which include statements of delegation of duties, responsibilities, and lines of authority and accountability;	1 2 3 4 5 6	
	B. Communication between program administration, coordinator(s) team services personnel, medical director, medical staff, (if there is one) and the governing body;	1 2 3 4 5 6	
	C. Compliance with applicable laws and regulations;	1 2 3 4 5 6	
	D. A management reporting system which provides understandable and standardized reports;	1 2 3 4 5 6	
	E. Ongoing assessment of community hospice care needs reflected in the long and short term plans of the program;	1 2 3 4 5 6	
	F. Efforts to obtain community support and input to the programs.	1 2 3 4 5 6	
8.1.6	There are written plans to guide and confirm the implementation of the personnel policies and procedures stated in CHAPTER EIGHT of this Guide.	1 2 3 4 5 6	
8.1.7	There is a written plan stating the method and frequency of review of all program and team service policies and procedure at least annually.	1 2 3 4 5 6	
	A. The plan includes the composition and qualifications of the review committee;	1 2 3 4 5 6	
	B. How revisions will be initiated;	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
8.1.7	C. A statement of who will approve policies, procedures, and revisions;	1 2 3 4 5 6	
	D. There is evidence by initial of the annual review of all policies and procedures.	1 2 3 4 5 6	
8.1.8	There are written fiscal policies and practices that confirm the implementation of at least the following:		
	A. An annual revenue and expense budget with line items paralleling the program's plan of organization;	1 2 3 4 5 6	
	B. A budgetary process with participation of at least the the program director, coordinator(s), and governing body;	1 2 3 4 5 6	
	C. An annual outside certified financial audit;	1 2 3 4 5 6	
	D. Control of accounts receivable and payable, the handling of cash, and credit arrangements;	1 2 3 4 5 6	
	E. Preparation in accordance with program policy of comparative financial statements of budget vs. actual on an accrual basis;	1 2 3 4 5 6	
	F. Reports on the nature and extent of funding and other available financial resources.	1 2 3 4 5 6	
8.1.9	There are written plans for the collection and analysis of statistical data relevant to the program evaluation.	1 2 3 4 5 6	

DOCUMENTATION Requested for Survey

- Job description and qualifications of hospice program director.
- Program and policy and procedure statements regarding:
  - management and administration
  - personnel policy
  - fiscal administration
  - program evaluation
  - policy review
- Program budget and most recent financial review statement.
- Most recent management statistical report.

HOSPICE PROJECT
SELF ASSESSMENT AND SURVEY GUIDE

PERSONNEL POLICIES AND PROCEDURES

Goal I: Hospice program personnel policies and procedures are developed, adpoted, and maintained. These policies and procedures promote the objectives of the hospice services and provide for an adaquate number of qualified personnel, during all hours of operation, to support the hospice services of the program and the provision of high quality care.

Recommended Completion by: The Hospice Program Personnel Director, or person responsible for personnel, or the Hospice Program Director.

Completed by and Title: _____

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
9.1.1.	The staff member(s) responsible for implementing and coordinating personnel policies and procedure and maintaining personnel records is:		
9.1.2	Date(s) personnel policies adopted for hospice services.		
9.1.3	Indicate who approved policies, and date of most recent review.		
9.1.4	There is a written organizational plan for personnel services, including supervision of employment related forms.	1 2 3 4 5 6	
9.1.5	There are written hiring practices consistent with the needs of the hospice program and the services it provides.	1 2 3 4 5 6	
	The hiring practices include at least the following:		
	A. Written criteria for the selection of each employee that is demonstrably related to the job under consideration;	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA			RATING	BASE DATA
9.1.5	B.	A written policy concerning the availability of bilingual personnel when people who speak languages other than English make substantial use of the program.	1 2 3 4 5 6	
9.1.6		Personnel records are maintained to assure confidentiality.	1 2 3 4 5 6	
9.1.7		There are written personnel policies and procedures which pertain to at least the following:	1 2 3 4 5 6	
	A.	Employee benefits;	1 2 3 4 5 6	
	B.	Recruitment, termination and selection of employees;	1 2 3 4 5 6	
	C.	Employee grievance and appeals procedure;	1 2 3 4 5 6	
	D.	Safety, and Employee incidents reports;	1 2 3 4 5 6	
	E.	Wages, hours, and salary administration;	1 2 3 4 5 6	
	F.	Rules of conduct;	1 2 3 4 5 6	
	G.	Disciplinary systems;	1 2 3 4 5 6	
	H.	Equal employment opportunities and affirmative action policies;	1 2 3 4 5 6	
	I.	Liability insurance;	1 2 3 4 5 6	
	J.	Acceptance of gratuitues;	1 2 3 4 5 6	
	K.	Determination that all personnel are medically capable of performing assigned tasks.	1 2 3 4 5 6	
9.1.8		There are written personnel policies stating at least the lines of authority and reporting of all hospice employees including volunteers.	1 2 3 4 5 6	
9.1.9		Procedures are implemented to assure compliance with federal, state, and local law related to employment practices.	1 2 3 4 5 6	
9.1.10		There is written documentation to verify that hospice program personnel policies and procedures apply to all program employees;	1 2 3 4 5 6	
	A.	Are made available to and explained to each employee;	1 2 3 4 5 6	
	B.	Are available to others upon request;	1 2 3 4 5 6	
	C.	And there is a mechanism to notify employees of changes in policy and procedures.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA			RATING	BASE DATA
9.1.11		There is written documentation of a staff orientation program initiated on or during the first week of employment.	1 2 3 4 5 6	
9.1.12		Number of Inpatient employees		
	A.	Number of contracted employees		_____
9.1.13		Number of Home Care employees		
	A.	Number of contracted employees		_____
9.1.14		A personnel record is maintained for each staff member.	1 2 3 4 5 6	
9.1.15		The record contains the following information:		
	A.	Application for employment;	1 2 3 4 5 6	
	B.	Documentation of references either written or verbal;	1 2 3 4 5 6	
	C.	Verification of licensure and certification and/or renewals;	1 2 3 4 5 6	
	D.	Wage and salary information, including adjustments;	1 2 3 4 5 6	
	E.	Performance appraisals;	1 2 3 4 5 6	
	F.	Initial and subsequent health clearances;	1 2 3 4 5 6	
	G.	Counseling actions;	1 2 3 4 5 6	
	H.	Disciplinary actions;	1 2 3 4 5 6	
	I.	Commendations;	1 2 3 4 5 6	
	J.	Incident reports;	1 2 3 4 5 6	
9.1.16		There is a written job description for each position in the program.	1 2 3 4 5 6	
		The job description includes the following:		
	A.	Position title;	1 2 3 4 5 6	
	B.	Department, service or unit;	1 2 3 4 5 6	
	C.	Direct supervisor's title;	1 2 3 4 5 6	
	D.	Positions supervised and degree of supervision;	1 2 3 4 5 6	
	E.	Tasks and responsibilities of the job;	1 2 3 4 5 6	
	F.	The minimum level of education, training, and/or related work experience required;		
	G.	Documentation of revision and changes in qualifications, duties, supervision, and other major job-related factors.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
9.1.17 There are written performance appraisals		
A. in the employee personnel record;	1 2 3 4 5 6	
B. they are related to the job description and stated performance expectations;	1 2 3 4 5 6	
C. and are conducted during the initial employment period;	1 2 3 4 5 6	
D. and at least annually thereafter;	1 2 3 4 5 6	
E. there is documentation that the employee has reviewed the evaluation and has had an opportunity to comment upon it.	1 2 3 4 5 6	

REQUESTED DOCUMENTATION FOR SURVEY

- Personnel policy and procedures
- Personnel records

HOSPICE PROJECT
SELF ASSESSMENT AND SURVEY GUIDE

UTILIZATION REVIEW

Goal I: Appropriate allocation of hospice resources is demonstrated by conducting a utilization review program that includes the hospice program and interdisciplinary team services.

Recommended completion by: The hospice program director or a representative of the utilization review committee.

Completed by and Title: _____

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
10.1.1.	There is a written plan describing the utilization review program and governs its implementation.	1 2 3 4 5 6	
	A. The plan is approved by the governing body and the hospice program director.	1 2 3 4 5 6	
10.1.2	The written plan includes, but is not limited to the following:		
	A. The composition of the committee that includes at least one representative from each of the interdisciplinary team services and the program services;	1 2 3 4 5 6	
	B. The responsibility and authority of committee members;	1 2 3 4 5 6	
	C. A conflict of interest policy applicable to all review activities, and as determined by the program, to resultant findings and recommendations;	1 2 3 4 5 6	
	E. A description of the method(s) used to identify utilization related problems;	1 2 3 4 5 6	
	F. Procedures for conducting concurrent and retrospective reviews;	1 2 3 4 5 6	
	G. A description of how the findings of the committee will be interrelated with the quality assurance program;	1 2 3 4 5 6	
	H. The frequency of committee meetings;	1 2 3 4 5 6	
	I. The composition and dissemination of a report of the committee's findings at least annually.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
10.1.3	The committee reviews at least twice annually a defined number of medical records selected randomly through a specific method to review the appropriateness and adequacy of services provided.	1 2 3 4 5 6	
10.1.4	There is ongoing retrospective and concurrent monitoring of the utilization of program and team services.	1 2 3 4 5 6	
10.1.5	The procedures for conducting concurrent review have the following characteristics:		
	A. Program specific time periods following admission within which the review is initiated;	1 2 3 4 5 6	
	B. The length of stay norms and percentiles used in assigning continued-stay review dates that are program specific determined;	1 2 3 4 5 6	
	C. Utilization of factors other then or in addition to payment source as the basis for determination of which patients receive concurrent review;	1 2 3 4 5 6	
	D. Written measureable criteria and length-of-stay norms are approved by the utilization review committee and the hospice program administration.	1 2 3 4 5 6	
	E. Please state the current average length of stay for:	1 2 3 4 5 6	
	home care patients		No. of days ____
	inpatient care patients		No. of days ____
	F. Please state the program length of stay norm utilized:		
	home care patients		No. of days ____
	inpatient care patients		No. of days ____
10.1.6	There is a written plan for initiating discharge planning or transfer to another hospice program service, or from the hospice program when care is no longer needed or appropriate. The plans include delineation of the responsibility for initiation and follow-through.	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
10.1.7	There is evidence that the findings and recommendations of the committee are the basis of action in the past twelve months in any one of the following areas:		
	1. Administration or supervision;	1 2 3 4 5 6	
	2. Inservice or continuing education;	1 2 3 4 5 6	
	3. Meeting regulatory or legal requirements;	1 2 3 4 5 6	
	4. Patient services	1 2 3 4 5 6	
10.1.8	There is evidence that the utilization review program, including the written plan, discharge criteria, and length-of-stay norms are reviewed at least annually and revised as is appropriate.	1 2 3 4 5 6	

DOCUMENTATION Requested During Survey

- Written plan
- List of committee members
- Criteria utilized in review
- Committee report and recommendations

HOSPICE PROJECT
SELF ASSESSMENT AND SURVEY GUIDE

QUALITY ASSURANCE

Goal I: The hospice program has a well-defined, organized quality assurance program to enhance patient/family care through the ongoing objective assessment of important aspects of patient/family care and the correction of identified problems.

Recommended completion by: The individual responsible for the quality assurance program or by the hospice program director.

Completed by and Title: _____

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
11.1.1.	The hospice program director designates a committee to implement and maintain the quality assurance program.	1 2 3 4 5 6	
11.1.2	The committee includes representatives from hospice program administration, interdisciplinary team services, program services, and the medical staff of the inpatient care service.	1 2 3 4 5 6	
11.1.3	There is a written plan defining the type and the frequency of all quality assurance activities in the hospice program.	1 2 3 4 5 6	
11.1.4	The written plan includes, but is not limited to the following:		
	A. A quality assurance program is developed, adopted, and implemented for EACH of the following team services and program services:		
	1. bereavement services;	1 2 3 4 5 6	
	2. nursing services;	1 2 3 4 5 6	
	3. physician services;	1 2 3 4 5 6	
	4. psycho-social support services;	1 2 3 4 5 6	
	5. volunteer services;	1 2 3 4 5 6	
	6. home care services;	1 2 3 4 5 6	
	7. inpatient care services.	1 2 3 4 5 6	

	SELF ASSESSMENT & SURVEY CRITERIA	RATING	BASE DATA
	B. The findings of the monitoring, evaluation, and problem solving activities of EACH of the preceeding plans is integrated into the overall hospice program quality assurance activities.	1 2 3 4 5 6	
	C. Responsibility is delegated in the plan for the implementation and reporting for each service quality assurance plan and for the overall program integrated quality assurance program.	1 2 3 4 5 6	
11.1.5	Findings of the quality assurance plans throughout the program are reported as defined in policy to the governing body, the hospice program administration, and the team and the program service coordinators.	1 2 3 4 5 6	
11.1.6	The individual service quality assurance plans and the overall hospice program quality assurance program includes at least these five components: A. Problem identification; B. Problem assessment; C. Problem correction; D. Problem monitoring; E. Evaluation, documentation, and follow up.	1 2 3 4 5 6	
11.1.7	The quality assurance program includes identification of important and/or potential problems or related concerns in the care of patients and families through at least the following sources of data:	1 2 3 4 5 6	
	A. findings of the quality assurance activities of each service;	1 2 3 4 5 6	
	B. Utilization review findings;	1 2 3 4 5 6	
	C. Incident reports.	1 2 3 4 5 6	
11.1.8	The quality assurance program includes objective assessment of the cause and the scope of problems and concerns identified. The problem assessment has the following characteristics:	1 2 3 4 5 6	
	A. Prespective, concurrent, and retrospective assessment of the actual or potential problem identified;	1 2 3 4 5 6	

SELF ASSESSMENT & SURVEY CRITERIA		RATING	BASE DATA
	B. Evaluation of the problem that represents an adequate sampling of the services, disicplines and individuals involved;	1 2 3 4 5 6	
	C. Use of written criteria for assessment that when applied to actual practice can result in measurable improvement in regard to patient care and clinical performance.	1 2 3 4 5 6	
11.1.9	The quality assurance program designates methods for implementation of decisions or actions that are designed to eliminate or reduce identified problems.	1 2 3 4 5 6	
11.1.10	There is evidence that the recommendations of the quality assurance committee are the basis of action in the past twelve months in any one of the following areas:		
	A. Administration or supervision;	1 2 3 4 5 6	
	B. inservice or continuing education;	1 2 3 4 5 6	
	C. patient services.	1 2 3 4 5 6	
11.1.11	There is evidence that the individual service quality assurance plans and the overall hospice program quality assurance program is reviewed at least annually and revised as is appropriate.	1 2 3 4 5 6	

HOSPICE SELF ASSESSMENT AND SURVEY GUIDE
QUESTIONNAIRE

ORGANIZATION NAME: _____

REVIEWER NAME: _____

TITLE: _____

ORGANIZATION ADDRESS: _____
Street or P.O. Box

_____
City State Zip Code

1. Date hospice program became operational: _____

2. Date of first admission: _____

3. Please indicate which administrative structure best characterizes your own:

   _____ a. Hospital Owned

   _____ b. Community Agency Owned

   _____ c. Independently Owned

   If a. or b. apply, is hospice care:

   _____ Provided within a separate unit or by a separate team; or

   _____ Integrated into current services but hospice patients identified.

4. Do you currently contract for any hospice services: _____ Yes _____ No

   If yes, please indicate the type of service:

   _____ Home Care _____ Inpatient _____ Other, Please Indicate:

   _____

   _____

5. Check the licensure category within which your hospice program exists (if any):

   _____ Licensed HH Agency

   _____ Acute Care Hospital

   _____ Intermediate Care Facility

   _____ SNF

   _____ Hospice

   _____ Other _____

   _____ No License

V. "WEIGHTED" STANDARDS

Please feel free to indicate with a "W" in the left hand margin, those characteristics which you feel most indicate compliance with a goal.

VI. WHERE DO WE GO FROM HERE?

At the conclusion of the pilot tests in August, we will again review the standards and the self-assessment and survey guide with regard to the results of the pilot tests and the written comment received to date. Then the following process will occur:

1. A draft will be presented to the Hospice Advisory Committee for vote of approval in October 1982.
2. The approved draft will be presented along with study results at two workshops at the NHO Annual Meeting in November in Washington, D.C.
3. The approved draft will also be presented to the Standards and Survey Procedure Committee of the JCAH for approval in November 1982.
4. The draft approved by the S-SP committee will be presented to the Board of Commissioners of the JCAH in December of 1982.
5. A final report will be filed with the W.K. Kellogg Foundation and the final draft prepared for publication.

At this time, no accrediting body has chosen to initiate national hospice program accreditation.

Please note this is the last opportunity for input before the final draft is presented to the above committees.

Your comments, the questionnaire, and the guide as you choose to complete it, are due to be returned by AUGUST 20, 1982. In view of the above schedule, there will not be an extended period for comment.

I greatly appreciate your continued time, effort, and cooperation in this project. With your input, we will be able to produce a document that reflects quality hospice care for all providers and for the patients and the families they care for. Thank you.

Barbara A. McCann
Hospice Project Director

6. Is your organization currently certified by:

_____ Medicare
_____ Medicaid
Specify type _____

7. Is your organization currently accredited by:

_____ NLN/APHA
_____ JCAH
_____ Other _____
_____ Not accredited

8. Is your organization:

_____ Profit
_____ Nonprofit

9. Is your annual hospice operating budget:

_____ Under 25,000
_____ 25,000 to 75,000
_____ 75,000 to 150,000
_____ 150,000 to 300,000
_____ Over 300,000

10. Source of Funds (by percentage):

_____ Fees (private pay)
_____ Foundations
_____ Donations
_____ Medicare
_____ Medicaid
_____ Private Insurance
_____ Other (please specify) _____

11. Do you currently bill the following for services provided to hospice patients:

Medicare	_____ Yes	_____ No
Medicaid	_____ Yes	_____ No
Blue Cross/Blue Shield	_____ Yes	_____ No
Other _____		

12. Do you feel there is a need for the establishment of "voluntary accreditation" for hospice care?

_____ Yes _____ No

(Please check one)

a. _____ Within the next year

b. _____ Within the next one to two years.

13. If a voluntary accreditation program was available, would your organization participate?

_____ Yes _____ No

A. If you answered no, is the basis of your reply (please check one)

a. _____ Lack of funds for accreditation.

b. _____ Do not feel accreditation is necessary.

14. If funding was available to assist with the cost of accreditation based on program budget and determined need, would your program participate in voluntary accreditation?

_____ Yes _____ No

15. Which of the following organizations would you prefer to provide an accreditation program for a Hospice (indiate first, second, third choice):

_____ Federal Government
_____ State Government
_____ JCAH
_____ NHO
_____ NLN/APHA
_____ Other (please specify) _____

16. What is the maximum amount that your organization would allocate for an accreditation survey?

_____ ∠1,000.00
_____ 1,000.00
_____ 1,500.00
_____ 2,000.00
_____ 3,000.00

17. If your facility is presently accredited, would you prefer the Hospice survey for accreditation to be done concurrently?

_____ Yes _____ No

A. If yes, please indicate current accrediting body:

_____ JCAH
_____ NLN/APHA
_____ Other, please indicate:

_____

_____

Additional Comments: _____

_____

_____

Thank You.

Please return to: Barbara A. McCann
Hospice Project Director
Joint Commission on Accreditation of Hospitals
875 N. Michigan Ave.
Chicago, IL 60611

SUPPLEMENTARY MATERIAL FOR ASSISTANCE IN THE REVIEW OF

THE PROPOSED HOSPICE PROJECT SELF ASSESSMENT AND SURVEY GUIDE

I. SELF-ASSESSMENT AND SURVEY GUIDE DEVELOPMENT

The self-assessment and survey guide was developed through a series of steps in the past four months. The primary source document was the original draft of the Hospice Project Standards presented to the field for review in February 1982, with a comment period which ended June 4, 1982. The enclosed guide is the result of the following process:

1. Review by members of the Hospice Advisory Committee which includes representatives of the National Hospice Organization, and other major health care organizations.
2. Review by the JCAH staff of all current accreditation and standards development programs.
3. Review by the national hospice project consultant and review panel members who represent hospice providers in hospital-based, home health agency based, and independently owned hospice programs throughout the country as well as independent consultants in the field.
4. Recommended revisions from the 666 participants at the six national JCAH sponsored standards conferences, and the three NHO sponsored presentations.
5. Written comments received from providers and professional health care organizations, and third party payors throughout the country.

Our goal has been to present a draft for your review and comment which we feel encompasses the recommended revisions received to date in review, as well as maintains those elements relating to quality hospice care.

II. THE "ANATOMY" OF THE SELF-ASSESSMENT AND SURVEY GUIDE

As in the original document, a chapter consists of several goals. The goals as stated in the draft guide are in many cases REVISED GOALS AS A RESULT OF THE FIELD REVIEW. To date this is the only document that reflects the majority of changes recommended in the review process, please note and comment on those changes.

The characteristics noted following each goal are those measurable elements identified which we feel denote compliance with the goal. Please remember the following elements in your review:

1. No one hospice program can meet all the characteristics as stated, the standards represent an achievable, but optimal level of care-goals to be attained in many cases.
2. Not all characteristics are surveyed. There are "weighted" characteristics in each chapter that will ultimately define compliance with a goal. These will be determined based on your input.
3. Some characteristics are not applicable based on the size, complexity, and make-up of your program. For example, a small volunteer program would indicate that the complex characteristics relating to administration and organization are not applicable. However the goal for planning and management is. The larger hospice programs would respond to the variety of organizational questions. Or simply, the characteristic may not be applicable because you do not provide that service.

4. Please remember the concept of "equivalency", if the intent of the goal or characteristic is met by a mechanism other than what is defined as in the guide, that does constitute compliance.

III. THE REVIEW PROCESS: COMMENT AND INFORMATION PROVIDED

The review process consists of two parts for this document, and we request your participation in both segments.

A. The Questionnaire

We are asking that you complete the initial three page short questionnaire to again provide us with important information about where hospice programs are now and your feelings about accreditation in the future.

B. The Self-Assessment and Survey Guide

We will be field testing the standards and the guide at fifteen programs during the summer. The programs are hospital-based, home health agency based, and independently owned hospice programs; they are inpatient and home care only programs, and some who offer both either through written or verbal agreement; some have all paid professional staff, some have one or two paid staff, and the remainder are volunteers; they are in both rural and urban areas.

However we would like more information as to what is achievable now in hospice care. Therefore we want information from more than just fifteen sites. So I am asking that you respond to the guide in your review AS IF YOU WERE GOING TO BE SURVEYED, and return that information to us. A word of caution, this information will be used to determine a level of compliance for the country. If you feel your program cannot meet a characteristic, please indicate non-compliance. If the majority of programs cannot meet a given characteristic perhaps it should be modified or not weighted heavily in an accreditation decision.

NOTE: All information accumulated will be held in confidence, and reports will be stated only in the aggregate. If you do not feel comfortable returning the information and being identified, please complete the questionnaire without stating the name of your organization.

IV. THE RATING SCALE:

The following is the rating scale guide with some examples:

1=	Substantial compliance	The intent of the characteristic is met.
2=	Significant compliance	There is evidence that you are taking action to meet the intent of the characteristic and you will be compliant within the next two months.
3=	Partial compliance	There is evidence of a plan to meet the intent, but time is required to evaluate if the intent will be met.
4=	Minimal compliance	Evidence of efforts to meet the intent have been initiated, but are minimal.
5=	No compliance	
6=	Not Applicable	

FOOTNOTES

FOOTNOTES

[1]Bible, Ecclesiastes 3:2, Genesis 3:19, 2 Corinthians 4:7-12, etc.

[2]Barney G. Glaser and Anselm L. Strauss. Awareness of Dying, Chicago: Aldine Publishing Company, 1965: p. 3.

[3]Ruth V. Gray. "Dealing with the Patient: Some Physiological Needs," in Dealing with Death and Dying, A Nursing Skillbook Edited By Patricia S. Chaney, Horsham, PA: Intermed Communications, Inc., 1976; p. 7.

[4]Edwin S. Shneidman, Editor. Death: Current Perspectives; Palo Alto, California: Mayfield Publishing Company, 1976; pp. 516, 293 and 315.

[5]JCAH Perspectives, November/December, Vol. 2, No. 6, p. 6.

[6]Elizabeth Kubler-Ross. On Death and Dying. New York: MacMillan Company, 1969; pp. 1 and 2.

[7]Edwin S. Shneidman, Editor. Death: Current Perspectives; Palo Alto, California: Mayfield Publishing Company, 1976; p. 147.

[8]Interview, Barbara A. McCann, Director of Hospice Project, JCAH, 19 October 1982, Chicago.

[9]Memorandum for Director through Deputy Director, Subject: Hospice: The Projects for Terminal Care Coverage Under CHAMPUS--Concept Paper, Written by Joseph C. Re, Program Advisor. DOD Office, Civilian Health and Medical Programs of the Uniformed Services dated March 15, 1982.

[10]Mary Lou Weisman. "Death of a Son: A Love Story." Family Weekly (24 October 1982); pp. 11 and 12.

[11]Package of Material from VA Medical Center, Denver, CO, page 1 of proposal for A Palliative Treatment Program at the Denver Veterans Administration Medical Center.

[12]Richard G. Benton. Death and Dying: Principles and Practices in Patient Care. New York: D. Van Nostrano Company, 1978; p. 51.

[13]Joint Commission on Accreditation of Hospitals. "Hospice Project Self-Assessment and Survey Guide." 25 June 1982, Chicago, John E. Affeldt, President, JCAH, and Barbara A. McCann, Hospice Project, Director, Supplementary Material; p. 2.

[14]Ibid.

[15]Joint Commission on Accreditation of Hospitals. "Hospice Project Self-Assessment and Survey Guide." 25 June 1982, Chicago, John E. Affeldt, President, JCAH, and Barbara A. McCann, Hospice Project, Director.

[16]Headquarters, Department of the Army, Washington, D.C., AR 40-3, Medical Services, Subject: Medical, Dental, and Veterinary Care, dated 10 October 1977.

[17]CHAMPUS Handbook, 1978-1979, p. 39.

[18]Glen W. Davidson, "Five Models for Hospice Care." The Journal of Quality Assurance, Vol. 5, No. 5 (May 1979); p. 8.

[19]Melvin J. Krant, "Hospice Philosophy in Late-State Cancer Care." Journal of American Medical Association, Vol. 245, No. 10 (March 13, 1981); p. 1062.

[20]Robert S. Brown, Nancy Massman, and Kathy Wornson, "Hospice Home Care." Minnesota Medicine (March 1981); p. 155.

[21]Robert F. Rizzo, "Hospice." New York State Journal of Medicine 78 (October 1978); p. 1902.

[22]Robert M. Cunningham, Jr., "When Enough is Enough." Hospitals (July 1, 1979); p. 64.

[23]Teresa Marie McIntier, "Hillhaven Hospice: A Free-Standing, Family-Centered Program." Hospice, Vol. 60, No. 3 (March 1979); p. 64.

[24]Robert M. Cunningham, Jr., "When Enough is Enough." Hospitals (July 1, 1979); p. 63.

[25]Richard P. Ames, David Mineau, and Kathy Petrushevich, "Mercy Hospice: A Hospital-Based Program." Hospice, Vol. 60, No. 3 (March 1979); p. 64.

[26]Ira S. Goldenberg, "Hospice: To Humanize Dying." American College of Surgeons Bulletin 18 (April 1979); p. 9.

[27]Richard P. Ames, David Mineau, and Kathy Petrushevich, "Mercy Hospice: A Hospital-Based Program." Hospice, Vol. 60, No. 3 (March 1979); p. 64.

[28]Jack G. Coale, "The Hospice in the Health Care Continuum." The Journal of Quality Assurance, Vol. 5, No. 5 (May 1979); p. 23.

[29]Enrique Mendez, Jr., MG, MC, Acting The Surgeon General, Washington, D. C., 20310. 1st Indorsement, subject: Texas Natural Death Act, dated 23 May 1978 (unpublished).

[30]James G. Zimmerly, LTC, Chairman, Department of Legal Medicine, Armed Forces Institute of Pathology, Walshington, D.C. 20306. Letter, subject: Life Support Measure for Terminal Patients, dated 7 September 1978.

[31]Joint Commission on Accreditation of Hospitals. "Hospice Project Self-Assessment and Survey Guide." 25 June 1982, Chicago. John E. Affeldt, President, JCAH, and Barbara A. McCann, Hospice Project, Director.

[32]Scott Goodman, "Hospice Fills Need for Care of Terminally Ill Patients." Pennsylvania Medicine 82 (December 1979); p. 27.

[33]"Final Draft of Hospice Standards Developed." JCAH Perspectives, November/December 1982, Vol. 2; p 6.

[34]Ann Martin, "Hospice Nursing: Walking a Fine Line." Nursing (February 1981); p. 128.

[35]William M. Markel and Virginia B. Sinon, "The Hospice Concept." The Journal of Practical Nursing 29 (March 1979); p. 25.

[36]Cicely Saunders, "Hospice Care." The American Journal of Medicine, Vol. 65, No. 5, Nov 78, p. 727.

[37]M. Elaine Graves. Hospice of Metro Denver, Inc., Annual Report, 1 January 1981 to 30 June 1982; p. 2.

[38]James H. Scully, Chief, Psychiatric Liaison Division, Veterans Administration, 1055 Clermont Street, Denver, CO 80220. Letter, subject: Working Papers, dated January 14, 1983.

[39]Hospice File, General Leonard Wood Army Community Hospital, Fort Leonard Wood, Missouri. Material includes Minutes from Hospice Care Team and MEDDAC Memorandum 40-81-1, dated 25 February 1981 and Request for Approval of Hospice dated 20 August 1981 (Robert H. Buker, COL(P)).

[40]Dorothea Guthrie, Assistant Editor. "Dr. Kubler-Ross: A Positive Acceptance of Death." American College of Surgeons Bulletin 18 (April 1979); p. 13.

[41]Richard P. Ames, "Unresolved Issues in Hospice Care: Models, Pain Control, Volunteers' Role." Hospital Progress, Vol. 62, No. 3 (March 1981); p. 49.

[42]Janice Barstow, "Stress Variance in Hospice Nursing." Nursing Outlook (December 1980); p. 753.

[43]William M. Markel, and Virginia B. Sinon, "The Hospice Concept." Cancer Journal for Clinicians, Vol. 28, No. 4 (August 1978); p. 232.

[44]Robert F. Rizzo, "Hospice." New York State Journal of Medicine 78 (October 1978); p. 1909.

SELECTED BIBLIOGRAPHY

SELECTED BIBLIOGRAPHY

Books

Benton, Richard G. Death and Dying: Principles and Practices in Patient Care. New York: D. Van Nostrano Company, 1978.

Bible, Ecclesiastes 3:2, Genesis 3:19, 2 Corinthians 4:7-12, etc.

Fulton, Robert L., Ed. Death and Identity. Bowie, Maryland; The Charles Press Publishers, Inc., 1976.

Glaser, Barney G., and Strauss, Anselm L. Awareness of Dying. Chicago: Aldine Publishing Company, 1965.

Glaser, Barney G., and Strauss, Anselm L. Time for Dying. Chicago: Aldine Publishing Company, 1968.

Gray, V. Ruth. "Dealing with the Patient: Some Physiological Needs." In Dealing with Death and Dying, A Nursing Skillbook Edited by Patricia S. Chaney, Horsham, PA: Intermed Communications, Inc., 1976.

Jackson, Edgar N. Understanding Grief. Nashville, Tennessee: Abingdon Press, 1957.

Kubler-Ross, Elizabeth. On Death and Dying. New York: MacMillan Company, 1969.

Maguire, Daniel C. Death by Choice. Garden City, New York: Doubleday and Company, Inc., 1973.

Moustakas, Clark E. Loneliness. Englewood; Cliffs, NJ: Prentice-Hall, Inc., 1961.

Schneidman, Edwin S., Editor. Death: Current Perspectives, Palo Alto, California, Mayfield Publishing Company, 1976.

Sudnow, David. Passing On: The Social Organization of Dying. Englewood Cliffs, NJ, Prentice-Hall, Inc., 1967.

Periodicals

Amenta, Madalon M. and Weiner, Arlene W. "Death Anxiety and General Anxiety in Hospice Workers." Psychological Reports (1981); p. 962.

Amenta, Madalon M. and Weiner, Arlene W. "Death Anxiety and Purpose in Life in Hospice Workers." Psychological Reports (1981); p. 920.

_____. American Hospital Association, Outreach March-April 1983, Vol. 41, No. 2; p. 2.

Ames, Richard P. "Starting a Hospice Requires Tenacity, High Standards." Hospital Progress, Vol. 61, No. 2 (February 1980); pp. 56-60.

Ames, Richard P. "Unresolved Issues in Hospice Care: Models, Pain Control, Volunteers' Role." Hospital Progress, Vol. 62, No. 3 (March 1981); pp. 48-51.

Ames, Richard P., Mineau, David, and Petrushevich, Kathy. "Mercy Hospice: A Hospital-Based Program." Hospice, Vol. 60, No. 3 (March 1979); pp. 63-67.

Angaran, David M. "My Magic Pill." American Journal of Hospital Pharmacy, Vol. 39 (September 1982); p. 1548.

Barstow, Janice. "Stress Variance in Hospice Nursing." Nursing Outlook (December 1980); pp. 751-754.

Berry, Joni I.; Pulliam, Charles C.; Caiola, Stephen M.; and Eckel, Fred M. "Pharmaceutical Services in Hospices." American Journal of Hospital Pharmacy, Vol 38, No. 7 (July 1981); pp. 1010-1014.

Brady, E. Michael. "Telling the Story: Ethics and Dying." Hospice, Vol. 60, No. 3 (March 1979); pp. 57-62.

Baird, Susan B. "Nursing Roles in Continuing Care: Home Care and Hospice." Seminars in Oncology, Vol 7, No. 1 (March 1980); pp. 28-38.

Breindel, Charles L., and O'Hare, Timothy. "Analyzing the Hospice Market." Hospital Progress (October 1979); pp. 52-55.

Brown, Robert S. "Care of the Dying/Hospice." Minnesota Medicine (October 1980); pp. 727 and 728.

Brown, Robert S. "Care of the Dying/Hospice." Minnesota Medicine (January 1981); pp. 43 and 44.

Brown, Robert S.; Massman, Nancy; and Wornson, Kathy. "Hospice Home Care." Minnesota Medicine (March 1981); pp. 155 and 156.

Brown, Robert S.; Massman, Nancy; and Wornson, Kathy. "Hospice Home Care: When Death Occurs." Minnesota Medicine (June 1981); pp. 368 and 369.

Buckingham, Robert W. and Lupu, Dale. "A Comparative Study of Hospice Services In the United States." American Journal of Public Health, Vol. 72, No. 5 (May 1982); pp. 455-462.

Butler, Robert N. "The Need for Quality Hospice Care." The Journal of Quality Assurance, Vol. 5, No. 5 (May 1979); pp. 2-7.

Butler, Susan. "The Homely Touch." Nursing Mirror, Vol. 154, No. 20 (May 19, 1982); pp. 46 and 47.

Callan, John P. "The Hospice Movement." Journal of American Medical Association, Vol. 241, No. 6 (February 9, 1979); p. 600.

Clarke, Dawn. "Nursing Care at a Hospice." Nursing Times, Vol. 76, No. 40 (October 2, 1980); p. 1810.

Coale, Jack G. "The Hospice in the Health Care Continuum." The Journal of Quality Assurance, Vol. 5, No. 5 (May 1979); pp. 22 and 23.

Copsey, Mary K. "Time to Care." Nursing Mirror, Vol. 153, No. 22 (November 25, 1981); pp. 318-40.

Corbett, Terry L., and Hai, Dorothy M. "Searching for Euthanatos: The Hospice Alternative." Hospice, Vol. 60, No. 3 (March 1979); pp. 38-45.

Cunningham, Robert M., Jr. "When Enough is Enough." Hospitals (July 1, 1979); pp. 63-65.

Dauber, Leonard G.; Margolies, Emma; Spangenberg, Sandra E.; Greenhill, Maurice H.; Escher, George C.; Terry, Jack; Danzig, Bernard; and Fisichelli, Natalie. "Hospice in Hospital." New York State Journal of Medicine (October 1980); pp. 1721-1723.

Davidson, Glen W. "Five Models for Hospice Care." The Journal of Quality Assurance, Vol. 5, No. 5 (May 1979); pp. 8 and 9.

Donovan, Helen. "The Hospice Movement, A Unifying Force?" Nursing Forum, Vol 19, No. 1 (1980); pp. 19-25.

Dorang, Edith S. "A VNA-Organized Hospice Volunteer Program." Nursing Outlook, Vol. 29, No. 3 (March 1981); pp. 170-173.

Dunphy, J. Englebert. "Rising Above Suffering and Death." American College of Surgeons Bulletin 18 (April 1979); pp. 10 and 11.

_____. "Experts Probe Issues Around Hospice Care." Hospitals (June 1, 1980); pp. 63-67.

Fath, Rev. Gerald. "Pastoral Care and the Hospice." Hospice, Vol. 60, No. 3 (March 1979); pp. 73-75.

Fox, Lynette Smeder. "Pain Management in the Terminally Ill Cancer Patient: An Investigation of Nurses' Attitudes, Knowledge, and Clinical Practice." Military Medicine, Vol. 147 (June 1982); pp. 455-459.

Goldenberg, Ira S. "Hospice: To Humanize Dying." American College of Surgeons Bulletin 18 (April 1979); pp. 6-9.

Goodman, Scott. "Hospice Fills Need for Care of Terminally Ill Patients." Pennsylvania Medicine 82 (December 1979); p. 27.

Guthrie, Dorothea, Assistant Editor. "Dr. Kubler-Ross: A Positive Acceptance of Death." American College of Surgeons Bulletin 18 (April 1979); pp. 12 and 13.

Hackley, John A. "Financing and Accrediting Hospices." Hospice, Vol. 60, No. 3 (March 1979): pp. 51-53.

Hatch, Edward W. and Boring, Nathan L. "Regional Hospice Network Offers System Benefits." Hospital Progress (March 1980); pp. 67-70.

Hatch, Edward W. and Maniatis, Bette. "Regional Hospice Network Assessed After First Year's Operation." Hospital Progress (June 1981); pp. 59-61.

Hirsch, Lawrence L. "Ethical and Practical Concerns In Hospice Care." Illinois Medical Journal (June 1981); pp. 357-360.

Hollandler, Neil and Ehrenfried, David. "Reimbursing Hospice Care: A Blue Cross and Blue Shield Perspective." Hospice, Vol. 60, No. 3 (March 1979); pp. 54-56 and 76.

_____. "Hospice--An Idea Whose Time Has Come." Journal of Iowa Medical Society 69 (July 1979); pp. 289-290.

_____. "Hospice Care Update: Many Questions Still to be Answered." Hospitals, Vol 55, No. 10 (May 16, 1981); p. 56.

_____. "Hospice Leaders Hear Promises of Federal Help and Words of Caution." Hospital Progress (November 1978); pp. 20, 21 and 24.

_____. "Final Draft of Hospice Standards Developed." JCAH Perspectives, November/December 1982, Vol. 2; pp. 5 and 6.

Jenkins, Lowell and Cook, Alicia A. "The Rural Hospice: Integrating Formal and Informal Helping Systems." Social Work (September 1981); pp. 414-416.

Johnson, Barbara A. and Smith, Howard L. "A Strategy for Integrating Hospice, Hospital Care." Hospital Progress, Vol 62, No. 11 (November 1981); pp. 52-56.

Keany, Kate; Hockley, Jo; Morrison; and MacKay, Lynn. "Care Studies in a Hospice." Nursing Times, Vol. 78, No. 29 (July 22-27, 1982); pp. 1241-1244.

Kent, Jerry. "Life Before Death." Nursing Times, Vol 77, No. 33 (August 112-18, 1981); pp. 1435-1437.

Krant, Melvin J. "Hospice Philosophy in Late-State Cancer Care." Journal of American Medical Association, Vol. 245, No. 10 (March 13, 1981); pp. 1061 and 1062.

Longest, Beaufort B., Jr. "Delivery Prospers in Diversity." Hospitals (April 1, 1980); pp. 91, 92 and 94.

Lunt, Barry and Hillier, Richard. "Terminal Care: Present Services and Future Priorities." British Medical Journal, Vol. 283 (29 August 1981); pp. 595-598.

Luxton, R. W. "The Modern Hospice and Its Challenge to Medicine." British Medical Journal (8 September 1979); pp. 583 and 584.

McCabe, Sheridan V. "An Overview of Hospice Care." Cancer Nursing, Vol. 5, No. 2 (April 1982); pp. 103-108.

McIntier, Teresa Marie. "Hillhaven Hospice: A Free-Standing, Family-Centered Program." Hospice, Vol. 60, No. 3 (March 1979); pp. 68-72.

Markel, William M., and Sinon, Virginia B. "The Hospice Concept." Cancer Journal for Clinicians, Vol. 28, No. 4 (August 1978); pp. 225-237

Markel, William M., and Sinon, Virginia B. "The Hospice Concept." The Journal of Practical Nursing 29 (March 1979); pp. 24-29 and 39.

Martin, Ann. "Hospice Nursing: Walking a Fine Line." Nursing (February 1981); pp. 128, 130 and 132.

Martin, M. Caroline. "Cooperation Marks Development of Hospice." Hospitals 53 (July 16, 1979); pp. 32, 41 and 44.

Matthews, Bridget. "Setting Up Terminal Care Units." Nursing Times, Vol. 76, No. 38 (September 18, 1980), Occasional Paper.

Melum, Mara Minerva. "Hospitals Must Change. Control Is The Issue." Hospitals (March 1, 1980); pp. 67-72.

Mudd, Peter. "High Ideals and Hard Cases: The Evolution of a Hospice." The Hastings Center, Vol. 12, No. 2 (April 1982); pp. 11-14.

Nitschke, Ruprecht; Humphrey, G. Bennett; Sexauer, Charles L.; Catron, Barbara; Wunder, Shirley; and Jay, Susan. "Therapeutic Choices Made by Patients with End-Stage Cancer." The Journal of Pediatrics, Vol. 101, No. 3 (September 1982); pp. 471-476.

O'Brien, Carole Lium and Saletta, Anne. "Home Health Care and Adult Day Health Care - Options for Serving Older Adults." Nursing Administration Quarterly, Vol. 4, No. 3 (Spring 1980); pp. 49-54.

Parkes, C. Murray. "Terminal Care: Evaluation of an Advisory Domiciliary Service at St. Christopher's Hospice." Post Graduate Medical Journal (October 1980); pp. 685-689.

Parks, Patricia. "Evaluation of Hospice Care is Needed." Hospitals (November 16, 1979); pp. 68 and 70.

Parks, Patricia. "Evaluation of Hospice Care Still Needed." Hospitals (November 16, 1980); pp. 56 and 102.

Parks, Patricia. "Focusing On Trends in Long-Term Care." Hospitals (December 16, 1979); pp. 43 and 46.

Parks, Patricia. "Hospice Care: Implications for Hospitals." Hospitals 53 (March 16, 1979); pp. 58-62.

Perroliaz, LaVerne E. and Mollica, Margaret. "Public Knowledge of Hospice Care." Nursing Outlook (January 1981); pp. 46-48.

Philpot, Terry. "St. Joseph's Hospice: Death - A Part of Life." Nursing Mirror, Vol. 151, No. 8 (August 21, 1980); pp. 20-23.

Rakove, Roberta. "Hospice Care: A Planning Perspective." The Journal of Quality Assurance, Vol. 5, No. 5 (May 1979); pp. 10-12.

Rizzo, Robert F. "Hospice." New York State Journal of Medicine 78 (October 1978); pp. 1902-1910.

Rizzo, Robert F. and Rizzo, Linda. "Hospice Program." New York State Journal of Medicine 79 (July 1979); pp. 1244-1247.

Ryndes, True, and Brown, Robert S. "Care of the Dying." Minnesota Medicine, Vol. 64, No. 12 (December 1981); pp. 774-775.

Saunders, Cicely. "Hospice Care." The American Journal of Medicine, Vo. 65, No. 5 (November 1978); pp. 726-728.

Saunders, Cicely. "The Hospice: Its Meaning to Patients and Their Physicians." Hospital Practice (June 1981); pp. 93-96, 101-103, 107 and 108.

Silverman, William A. "A Hospice Setting for Humane Neonatal Death." Pediatrics, Vol. 69, No. 2 (February 1982); p. 239.

Slack, Patricia. "The Hospice Comes of Age." Nursing Times, Vol. 76, No. 23 (June 5, 1980); p. 1034.

Smith, David H. and Granbois, Judith A. "The American Way of Hospice." The Hastings Center Report, Vol. 12, No. 2 (April 1982); pp. 8-10.

Spillane, Edward J. "An Analysis of Catholic-Sponsored Hospices." Hospice, Vol. 60, No. 3 (March 1979); pp. 46-50.

Strohl, Roberta Anne. "Hospice Care and Professional Coping." Journal of Nursing Care, Vol. 14, No. 6 (June 1981); pp. 21 and 25.

_____. "Study of Hospice Care Shows Need for More Cost-Effective Services." Hospitals, Vol. 56, No. 9 (1 May 1982); p. 48.

Sweetser, Carleton J. "Integrated Care: The Hospital-Based Hospice." The Journal of Quality Assurance, Vol. 5, No. 5 (May 1979); pp. 18-21.

Telban, Sharon Grace. "Death Anxiety and Knowledge about Death." Psychological Report (1981); p. 648.

Trafford, Abigail. "Doctor's Dilemma: Treat or Let Die?" U.S. News & World Report (December 6, 1982); 53-56.

Vachon, Mary L. S. "Staff Stress in Care of the Terminally Ill." The Journal of Quality Assurance, Vol. 5, No. 5 (May 1979); pp. 13-17.

Vaile, Ivan R. "Hospice or Rehabilitation Hospital? Alternatives for the Terminally Ill." CMA Journal, Vol. 120 (May 19, 1979); pp. 1291-1292.

Valentour, Louis F. "Hospice Design Keyed to Program Goals." Hospitals (February 16, 1980); pp. 140, 142 and 143.

Wald, Florence S.; Foster, Zelda; and Wald, Henry J. "The Hospice Movement as a Health Care Reform." Nursing Outlook, Vol. 28, No. 3 (March 1980); pp. 173-178.

Walker, Marcus L. "Current Concepts of Hospice Care." Journal of Nursing Care, Vol. 14, No. 6 (June 1981); pp. 13-15.

Weisman, Mary Lou. "Death of a Son: A Love Story." Family Weekly (24 October 1982); pp. 2-4.

Weller, Irene. "Hospice at Home." Nursing Mirror, Vol 153, No. 25 (December 16, 1981); pp. 36-39.

Werner, Paul T. "Family Medicine and Hospice Programs: A Natural Alliance." The Journal of Family Practice, Vol. 12, No. 2 (1981); pp. 367 and 368.

Wilkes, Eric. "General Practitioner in a Hospice." British Medical Journal, Vol. 282 (16 May 1981); pp. 1591-1594.

Whitefield, Jonathan M.; Siegel, Roberta E.; Glicken, Anita D.; Harmon, Robert J.; Powers, Linda K.; and Goldson, Edward J. "The Application of Hospice Concepts to Neonatal Care." Am J. Dis Child, Vol. 136 (May 1982); pp. 421-424.

Zimmerman, J. M. "Experience with a Hospice-Care Program for the Terminally Ill." Ann. Surg., Vol. 189, No. 6 (June 1979); pp. 683-690.

Unpublished Material

DiBella, Nicholas J., COL, MC, Chief, Hematology-Oncology Service, Fitzsimons Army Medical Center, Aurora, CO 80045. Disposition Form, subject; Change in NO-COR Regulation, dated 21 July 1981.

Discussion Paper prepared by the Staff of The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research for Discussion at the Commission's Meeting, Water Resources Council, Lower Level Conference Room, 2120 L Street, N. W., Washington, D., C., subject: Resuscitation and the Decision Against, dated January 8, 1982.

Graves, M. Elaine, Director of HMD, Inc. Personal Communications and Correspondence, November-December 1982.

Hill, Jay M., COL, MC, Chief, Department of OB-GYN, Fitzsimons Army Medical Center, Aurora, CO 80045. Comment 2, subject: Determination of Death Statute, dated 23 July 1981.

Hospice File, General Leonard Wood Army Community Hospital, Fort Leonard Wood, Missouri. Material includes Minutes from Hospice Care Team and MEDDAC Memorandum 40-81-1, dated 25 February 1981 and Request for Approval of Hospice dated 20 August 1981 (Robert H. Buker, COL(P)).

"Ill Man: Court Asked to Let Him Die." LA Times, October 3, 1981.

Joint Commission on Accreditation of Hospitals. "Hospice Project Self-Assessment and Survey Guide." 25 June 1982, Chicago. John E. Affeldlt, President, JCAH, and Barbara A. McCann, Hospice Project, Director.

Jordan, John C., Chief Deputy District Attorney, Eighteenth Judicial District, 2009 West Littleton Boulevard, Littleton, CO 80120. Letter, dated February 26, 1980.

"Life-Support Suit Patient in Coma." LA Times, October 16, 1981.

McCann, Barbara A., Hospice Project Director, Supplementary Material for Assistance in the Review of the Proposed Hospice Project Self Assessment and Survey Guide.

McCann, Barbara A., Director, Hospice Project, JCAH, 19 October 1982, Chicago, IL (Interview).

Mendez, Enrique, Jr., MG, MC, Acting The Surgeon General, Washington, D. C., 20310. 1st Indorsement, subject: Texas Natural Death Act, dated 23 May 1978.

Moushegian, Vahan, Jr., MAJ, JACG, Acting Chief, General Law Branch, Administrative Law Division, Office of the Judge Advocate General, Washington, D. C., 20310. Letter, subject: Request for Copy of Office Opinion, dated 13 August 1980.

Rice, Paul J., LTC, JAGC, Chief, General Law Branch, Administrative Law Division, The Pentagon, Washington, D.C., 20310. Indorsement, subject: Request for Legal Opinion--Texas Natural Death Act, dated 8 May 1978.

Sanders, Joe M., Jr., COL, MC, Acting Chief, Department of Pediatrics, Fitzsimons Army Medical Center, Aurora, CO 80045. Disposition Form, subject: Determination of Death Statute, dated 21 July 1981.

Scully, James H., Chief, Psychiatric Liaison Division, Veterans Administration, 1055 Clermont Street, Denver, CO 80220. Letter, subject: Working Papers, dated January 14, 1983.

U.S. Department of the Army. Office of the Judge Advocate. Medical Services. Procedures for NO-COR Orders. FAMC Regulation 40-16, Fitzsimons Army Medical Center, Aurora, CO 80045, dated 27 November 1978.

Yawn, Malcolm T., LTC, JAGC, Judge Advocate, Fitzsimons Army Medical Center, Aurora, CO 80045. Disposition Form, subject: Determination of Death Statute, dated 21 July 1981.

Yawn, Malcolm T., COL, Judge Advocate, Fitzsimons Army Medical Center, Aurora, CO 80045. Disposition Form, subject: Review of FAMC Reg 40-10 - Procedures for Determining Death Due to Irreversible Cessation of Brain Function, dated 19 October 1979.

Zimmerly, James G., LTC, Chairman, Department of Legal Medicine, Armed Forces Institute of Pathology, Washington, D.C. 20306. Letter, subject: Life Support Measure for Terminal Patients, dated 7 September 1978.

Zimmerly, James G., COL, MC, USA, Chairman, Department of Legal Medicine, Institute of Pathology, Washington, D. C., 20306. Letter, Subject: Termination of Life Support and Entering of No-Code Orders, dated 1 April 1982.